DOCKET

SUPREME COURT
OF THE UNITED STATES

No. 12-729
Title: Julie Heimeshoff, Petitioner
v.
Hartford Life & Accident Insurance Co., et al.
Docketed: December 14, 2012
Lower Ct: United States Court of Appeals for the Second Circuit
Case Nos.: (12-651)
Decision Date: September 13, 2012

Questions Presented

~~Date~~~	~~~~~~~Proceedings and Orders~~~~~~~~~~~~~~~~~~~~
Dec 11 2012	Petition for a writ of certiorari filed. (Response due January 14, 2013)
Dec 11 2012	Appendix of Julie Heimeshoff filed.
Jan 30 2013	DISTRIBUTED for Conference of February 15, 2013.
Feb 7 2013	Response Requested . (Due March 11, 2013)
Mar 11 2013	Brief of respondents Hartford Life & Accident Insurance Co., and Wal-Mart Stores, Inc. in opposition filed.
Mar 26 2013	Reply of petitioner Julie Heimeshoff filed. (Distributed)
Mar 27 2013	DISTRIBUTED for Conference of April 12, 2013.
Apr 15 2013	Petition GRANTED limited to Question 1 presented by the petition.
Apr 30 2013	The time to file the joint appendix and petitioner's brief on the merits is extended to and including June 25, 2013.
Apr 30 2013	The time to file respondents' brief on the merits is extended to and including August 20, 2013.
Jun 18 2013	Consent to the filing of amicus curiae briefs, in support of either party or of neither party, received from counsel for the petitioner.
Jun 19 2013	Consent to the filing of amicus curiae briefs, in support of either party or of neither party, received from counsel for respondents Hartford Life & Accident Insurance Co., and Wal-Mart Stores Incorporated.
Jun 25 2013	Joint appendix filed. (Statement of costs filed)
Jun 25 2013	Brief of petitioner Julie Heimeshoff filed.
Jul 2 2013	Brief amicus curiae of the United States filed.
Jul 2 2013	Brief amici curiae of AARP and National Employment Lawyers Association filed.
Jul 2 2013	Brief amicus curiae of United Policyholders filed.
Jul 22 2013	CIRCULATED.
Jul 23 2013	SET FOR ARGUMENT on Tuesday, October 15, 2013.

Aug 20 2013	Brief of respondents Hartford Life & Accident Insurance Co., and Wal-Mart Stores, Inc. filed. (Distributed)
Aug 27 2013	Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument filed.
Aug 27 2013	Brief amici curiae of American Council of Life Insurers, et al. filed. (Distributed)
Aug 27 2013	Brief amicus curiae of DRI - The Voice of the Defense Bar filed. (Distributed)
Sep 5 2013	Record from U.S.C.A. for 2nd Circuit is electronic.
Sep 19 2013	Reply of petitioner Julie Heimeshoff filed. (Distributed)
Oct 1 2013	Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument GRANTED.
Oct 15 2013	Argued. For petitioner: Matthew W.H. Wessler, Washington, D. C.; and Ginger D. Anders, Assistant to the Solicitor General, Department of Justice, Washington, D. C. (for United States, as amicus curiae.) For respondents: Catherine M.A. Carroll, Washington, D. C.

PETITION FOR WRIT OF CERTIORARI

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AND
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No. 12-729

In The
Supreme Court of the United States

JULIE HEIMESHOFF,

Petitioner,

v.

HARTFORD LIFE & ACCIDENT INSURANCE CO., and WAL-MART STORES, INC.,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES
COURT OF APPEALS
FOR THE SECOND CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED FOR REVIEW

1. When should a statute of limitations accrue for judicial review of an ERISA disability adverse benefit determination?

2. What notice regarding time limits for judicial review of an adverse benefit determination should an ERISA plan or its fiduciary give the claimant with a disability claim?

3. When an ERISA plan or its fiduciary fails to give proper notice of the time limits for filing a judicial action to review denial of disability benefits, what is the remedy?

LIST OF PARTIES

The parties to this action are listed in the caption: The Petitioner, Julie Heimeshoff, was plaintiff and appellant in the courts below. Respondents Hartford Life & Accident Insurance Company and WalMart Stores, Inc., were defendants and appellees.

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OPINIONS BELOW

Unpublished opinion of the Second Circuit Court of Appeals, No. 12-651-cv, Summary Order, September 13, 2012, *Heimeshoff v. Hartford Life & Accident Insurance Co., WalMart Stores, Inc.*, 2012 U.S. App. LEXIS 19269 (2d Cir. Sept. 13, 2012) (Parker, Wesley, Circuit Judges; and Gleeson, District Judge sitting by designation) reprinted at **Pet.App.1-4**. The Court of Appeals affirmed the ruling of the District Court, (**Pet.App.5-18**, unpublished Order dated Jan. 16, 2012), which granted Appellees' motion to dismiss Heimeshoff's action challenging Hartford Life & Accident Insurance Company's ("Hartford") denial of long-term disability benefits under ERISA, 29 U.S.C. §1132(a)(1)(B), as untimely. The District Court entered Judgment on January 23, 2012.

STATEMENT OF JURISDICTION

The Second Circuit issued its opinion on September 13, 2012. Heimeshoff did not seek rehearing. This Court's jurisdiction is invoked under 28 U.S.C. §1254(1).

STATUTES AND REGULATIONS INVOLVED

Title 29, United States Code, Sections 1001(a), (b); 1022(a), (b); 1104(a)(1); 1133(1); 1133(2).

Title 29, Code of Federal Regulations, Sections 2520.102-2(b), 2520.102-3(s); 2560.503-1(a), (b), (f)(3), (g)(1)(iv), (h), (j)(4).

INTRODUCTION

This Court should grant certiorari to resolve the conflict among the circuits over the important questions raised here: When does an ERISA plan's statute of limitations begin to run or accrue, what notice of the time limits for judicial review must ERISA plans provide to beneficiaries, and what is the remedy for the failure to provide that notice?

The courts have adopted three conflicting approaches to answer the question of accrual:

(1) A plan's statute of limitations cannot begin running until the claimant has exhausted administrative remedies and the plan has issued a formal, final adverse determination (Fourth and Ninth Circuits);[1]

(2) A plan's pre-denial statute of limitations is enforceable if "reasonable," as determined on a case-by-case basis (Second, Sixth, Seventh, Eighth, and Tenth Circuits);[2] and

(3) The plan must notify the claimant of the time limits for judicial review, in the SPD and adverse determinations, in compliance with ERISA

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[1] *White v. SunLife Assurance Co.*, 488 F.3d 240 (4th Cir. 2007); *Price v. Provident Life & Accident Ins. Co.*, 2 F.3d 986 (9th Cir. 1993).

[2] *Burke v. PriceWaterHouseCoopers LLP Long Term Disability Plan*, 572 F.3d 76 (2d Cir. 2009); *Rice v. Jefferson Pilot Fin. Ins. Co.*, 578 F.3d 450 (6th Cir. 2009); *Abena v. Metro. Life Ins. Co.*, 544 F.3d 880 (7th Cir. 2008); *Blaske v. UNUM Life Ins. Co. of Am.*, 131 F.3d 763 (8th Cir. 1997), *cert. denied*, 525 U.S. 812 (1998); *Salisbury v. Hartford Life And Acc. Co.*, 583 F.3d 1245 (10th Cir. 2009).

regulations;[3] and if it does not, the court will not allow the plan to assert the plan's limitations defense[4] or will equitably toll the limitations period[5] (First Circuit and a District Court in Second Circuit).

This lack of uniformity causes unequal access to judicial review, in violation of ERISA, 29 U.S.C. § 1001(b), requiring "ready access to Federal courts", and this Court's recognition of "higher-than-marketplace" standards required of ERISA fiduciaries. *Metropolitan Life Ins. Co. v. Glenn,* 554 U.S. 105, 115 (2008). A uniform accrual time for benefits-due statute of limitations is necessary to level the playing field for American workers and employers and protect access to judicial review. *Varity Corp. v. Howe*, 516 U.S. 489, 513 (1996); 29 U.S.C. §§ 1001(b); 1104(a)(1).

The first approach—that of the Fourth and Ninth Circuits—provides **a bright-line accrual time** for the statute of limitations, consistent with ERISA's goals for plan fiduciaries to act in the sole interests of beneficiaries, and also with the general purposes of statutes of limitations.

The third approach relies on the principle that judicial review is an integral part of the review process that ERISA guarantees to claimants. This solution, like that of the Fourth and Ninth Circuits, also satisfies ERISA's goals and gives clear notice to

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[3] 29 C.F.R. § 2560.503-1(b)(1), (2); (g)(1)(iv); (j)(4); 29 C.F.R.§§ 2520.102-2; 2520.102-3(s).

[4] *Novick v. Metropolitan Life Ins. Co.*, 764 F.Supp.2d 653 (S.D.N.Y. 2011).

[5] *Ortega Candelaria v. Orthobiologics LLC*, 661 F.3d 675 (1st Cir. 2011).

claimants to allow them their day in court. It resolves the tension between requiring exhaustion of administrative remedies and allowing plans to write their own limitations provisions, provides clarity to employees, courts, and the legal system, and benefits claimants as Congress intended through ERISA.

The remaining circuits, without enforcing the notice required by the regulations, impair the rights to judicial review, contrary to the ERISA statute, regulations, and Supreme Court decisions. These circuits enable plans to create moving accrual times for their limitations periods, tied to "proof of loss" provisions which allow the plan to require additional information and extend the time limits for administrative review, all the while running the countdown on the plan's statute of limitations for judicial review. Each further day of delay deprives claimants of that time to review their options and prepare for litigation. All this occurs without the plan fiduciary notifying the claimant of the time limits for judicial review, in violation of ERISA minimum regulations requiring such notice.[6] The evidence shows that the confusion and lack of uniformity among courts[7] deters claimants from pursuing their right to have claims denials reviewed in court,[8] and encourages forum shopping.[9]

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[6] 29 C.F.R. §2560-503.1(b)(1), (2); (g)(1)(iv); (j)(4); 29 C.F.R.§§2520.102-2; 2520.102-3(s).

[7] Research has revealed 110 decisions in federal appellate and district courts in every circuit since 2002 addressing these ERISA statutes of limitations issues, demonstrating the widespread scale of these issues.

[8] "[E]vidence suggests that participants are often too discouraged to exhaust their appeal rights after an initial adverse decision, even under circumstances where the review

This case presents the opportunity for this Court to rectify the inconsistency among courts and guide them back to the role Congress originally intended, that is, "for federal judges to ... 'fill the gaps' left by the statute in ways that furthered the purpose of protecting plan participants."[10] That purpose is to hold ERISA plan fiduciaries to higher-than-marketplace standards, interpreting plans "solely in the interests of the participants and beneficiaries". *Glenn*, 554 U.S. at 115; 29 U.S.C. §1104(1)(a), and to protect the right to judicial review of adverse benefit determinations. *Varity Corp. v. Howe*, 516 U.S. 489 (1996); 29 U.S.C. §1104(1)(a).

STATEMENT OF THE CASE

1. Heimeshoff's Benefits Claim.

Julie Heimeshoff, a Senior Public Relations Manager who worked for Wal-Mart since April 29, 1986, became eligible for Wal-Mart's ERISA plan (Group Long Term Disability Plan for Employees)

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will be 'external' and hence arguably neutral." Andrew Stumpff, *Darkness At Noon: Judicial Interpretation May Have Made Things Worse for Benefit Plan Participants Under ERISA Than Had The Statute Never Been Enacted*, 23 St. Thomas L. Rev. 221, 238 n.75 (Spring 2011)(citing Karen Pollitz et al., *Assessing State External Review Programs and the Effects of Pending Federal Patients' Rights Legislation* 5 (2002), available at http://www.kff.org/insurance/externalreviewpart2rev.pdf).

[9] *E.g.*, Aaron A. Reuter, *Limiting ERISA's Limitations Period Through The Use of Contractual Accrual Dates*, The ERISA Litigation Newsletter (April 2012), http://www.proskauer.com/publications/newsletters/erisa:litigation-newsletter-april-2012/, **Pet.App.97**. *See also* **Pet.App.90-113**.

[10] Stumpff, 23 St. Thomas L.Rev. at 236 (citing Oringer, at 429).

(the "policy" or "plan"), administered by Hartford. In January 2005, she began suffering from symptoms of fibromyalgia, chronic pain, and other conditions. She stopped working on June 8, 2005. **Pet.App.6**.

Heimeshoff filed a claim for long term disability (LTD) benefits with Hartford on **August 22, 2005. Pet.App.7**. Hartford asked for clarification regarding her application on **November 21, 2005, Pet.App.72**, stating that under the policy, Heimeshoff needed to submit "[w]ritten proof of loss to The Hartford within 90 days after the start of the period for which The Hartford owes payment".

This letter informed Heimeshoff that her claim would not be affected if the proof was not submitted by that time if "it was not possible to give proof within the required time", so long as it was given "not later than 1 year after it is due". **Pet.App.73**. Hartford also wrote Heimeshoff on **November 29, 2005,** indicating the benefits decision period could be extended. **Pet.App.74**.

On **December 8, 2005,** Hartford denied Heimeshoff's claim. **Pet.App.75**. Hartford denied the claim because it allegedly did not receive certain clarifying information from Heimeshoff's doctor. Nevertheless, even after the denial, Hartford made clear that Heimeshoff could still provide this information. *See* **Pet.App.77** (advising that "[t]he following information, not previously submitted, is necessary for a determination of your claim.")

This "adverse benefit determination"[11] letter informed Heimeshoff of the right to administratively

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[11] 29 C.F.R. §2560.503-1(b).

appeal the decision and "receive a full and fair review" by writing Hartford within 180 days. **Pet.App.78**. The letter stated that Heimeshoff was required to exhaust her administrative remedies before she could file suit: "After your appeal, and if we again deny your claim, you then have the right to bring a civil action under Section 502(a) of ERISA." **Pet.App.79**. The letter did not provide the time limit for Heimeshoff to bring a civil action, if her claim was denied.

Heimeshoff retained counsel in **May 2006,** to assist in appealing the December 2005 denial of benefits. **Pet.App.8**. On **May 31, 2006**, Hartford wrote Heimeshoff, explaining that she need not file a "formal appeal" and if Hartford received clarification of Heimeshoff's functionality, "we will reopen the claim." **Pet.App.80**.

On **May 24, 2007**, Heimeshoff provided the additional clarifying information to Hartford. **Pet.App.14**. On **June 5, 2007**, Hartford extended the deadline for filing additional information to **September 30, 2007. Pet.App.14**.

On **September 26, 2007**, Heimeshoff appealed Hartford's benefits denial. **Pet.App.9**. Hartford denied this appeal by letter dated **November 26, 2007, Pet.App.81**, informing Heimeshoff that her internal appeal remedies had been exhausted, and stating this was "our final decision and the file remains closed." **Pet.App.89**. This final adverse determination notified Heimeshoff that she could "bring a civil action under Section 502(a) of the Employee Retirement Income Security

Act of 1974 ("ERISA"). **Pet.App.89**. It did not provide time limits for filing a lawsuit.

2. Hartford Policy's Statute of Limitations.

Hartford's policy had the following deadlines for review of benefits denials: Under "Claims: ... Proof of Loss", it required "[w]ritten proof of loss must be sent to The Hartford within 90 days after the start of the period for which The Hartford owes payment. After that, The Hartford may require further written proof that you are still Disabled." **Pet.App.56**.

Under "Legal Actions", the policy stated: "[l]egal action cannot be taken against The Hartford: ... after the shortest period allowed by the laws of the state where the policy is delivered. This is 3 years after the time written proof of loss is required to be furnished according to the terms of the policy." **Pet.App.56**.[12]

Hartford's SPD did not set forth the time limit for filing a judicial action. **Pet.App.57-71**. It did, however, require Heimeshoff to exhaust her administrative remedies. **Pet.App.65-66**.

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[12] It is unclear from this provision which state's statute of limitations applies. If the policy was delivered in Arizona where Heimeshoff worked, the state statute is six years for contract actions applied to ERISA cases in the 9th Cir. *Wise v. Verizon*, Ariz.Rev.Stat. § 12-548; *Gonsor v. Continental Casualty Co.*, 515 F. Supp 2d 929 (ED Ark 2007). If the policy was delivered in Arkansas where WalMart is headquartered, the statute is five years for contract actions. Ark.Code Ann. § 16-56-105.

Initial subject matter jurisdiction was based on 29 U.S.C. §§ 1132(e)(1) and (f), and 28 U.S.C. §1331, as this matter arose under the Employee Retirement Income Security Act (ERISA), a federal law. The Second Circuit Court of Appeals had jurisdiction under 28 U.S.C. § 1291.

REASONS FOR ALLOWING THE WRIT

A. The Circuits Conflict Over The Accrual Time For ERISA Statutes of Limitation.

The reason courts have struggled with accrual of ERISA plans' statutes of limitation is that starting a limitations period before the plan finally denies a beneficiary's claim contradicts ERISA's well-established requirement that the beneficiary exhaust her administrative remedies before filing suit. *E.g., White v. Sun Life Assur. Co.*, 488 F.3d 240, 247 (4th Cir. 2007)(listing circuit cases); Andrew M. Campbell, J.D., *Exhaustion Of Administrative Remedies As Prerequisite To Suit Under ERISA*, 162 A.L.R. Fed. 1, §[2a] (1997-2005; Supp. 2012). Indeed, Hartford's plan, like many, **requires** the claimant to exhaust her administrative remedies before filing suit. **Pet.App.65-66**. At the same time, the limitations period begins running and wastes away while the claimant is going through the administrative review process.

In the comprehensive decision of *White*, the Fourth Circuit held this type of wasting limitations provision is unreasonable per se: under *White's* rule, the limitations period at issue does not accrue until

the plan has formally denied a benefits claim. The Ninth Circuit has followed this approach. *Price v. Provident Life & Accident Ins. Co.*, 2 F.3d 986, 988 (9th Cir. 1993).

The Second Circuit in *Burke v. PriceWaterHouseCoopers LLP Long Term Disability Plan*, 572 F.3d 76, 81 (2d Cir. 2009) declared it was joining the Fifth,[13] **Sixth, Seventh, Eighth and Tenth Circuits** "in upholding written plan terms including limitations periods which may begin to run before a claimant can bring legal action." Allowing wasting limitations provisions in this case-by-case manner is contrary to ERISA law and regulations guaranteeing a right of judicial review, and contrary to the purposes of a statute of limitations, **as there is no bright line** clearly telling claimants or ERISA fiduciaries when the clock starts running or when the limitations period expires. *See Rice v. Jefferson Pilot Fin. Ins. Co.*, 578 F.3d 450, 456 (6th Cir. 2009)("Because the parties have not provided any reason to ignore the plain language of the contract, and because we cannot find one, we hold that **the clear repudiation rule does not apply** and that the language of the contract governs"); *Abena v. Metro. Life Ins. Co.*, 544 F.3d 880, 884 (7th Cir. 2008) ("**in these circumstances,** application of the contractual limitations period is not unreasonable"); *Blaske v. UNUM Life Ins. Co. of Am.*, 131 F.3d 763, 764 (8th Cir. 1997) (claimant had time remaining

[13] The Fifth Circuit later noted that it had not joined these circuits and that *Burke* was incorrect in so stating. *Baptist Mem. Hosp.-Desoto, Inc. v. Crain Auto., Inc.*, 392 Fed. Appx. 289, 295 (5th Cir. 2010)(Fifth Circuit has not addressed whether plan's limitation period can begin to run before claimant has exhausted her remedies).

after plan's period expired; policy "is more liberal" than Minnesota statute), *cert. denied*, 525 U.S. 812 (1998); *Salisbury v. Hartford Life And Acc. Co.*, 583 F.3d 1245, 1249 (10th Cir. 2009) ("[w]e are not persuaded" by reasons advanced "for refusing to enforce the contractual limitations provision simply because the plan allowed the claimant's cause of action to accrue before the end of the administrative process") (all emphasis added).

A few courts have resolved the tension between ERISA's exhaustion of remedies requirement and contractual pre-denial accrual provisions by enforcing the notice regulations, §§ 2560.503-1(g)(1)(iv) and (j)(4), to require the insurer to provide time limits for judicial review. *See Novick v. Metro. Life Ins. Co.*, 764 F.Supp.2d 653 (S.D.N.Y. 2011)(insurer's failure to provide notice of time limits precluded it from asserting its contractual limitations defense; supplying forum state's six-year statute of limitations); *Ortega Candelaria v. Orthobiologics LLC*, 661 F.3d 675 (1st Cir. 2011)(insurer's failure to provide the time limits for judicial review justified equitably tolling the plan's limitations period); *Veltri v. Building Service 32B-J Pension Fund*, 393 F.3d 318 (2d Cir. 2004)(same). *See also Chappel v. Laboratory Corp. of America*, 232 F.3d 719 (9th Cir. 2000) (failure to provide notice of post-administrative arbitration requirement voided plan's time limit for arbitration).

Novick and *Ortega Candelaria's* remedies for notice violations honor ERISA's mandates and are consistent with acting solely in the interest of beneficiaries. 29 U.S.C. § 1104(a)(1).

Contrary to the Fourth and Ninth Circuits, in this case, the Second Circuit affirmed the District Court's dismissal of Heimeshoff's benefits-denial action based on its prior decisions in *Burke* and *Veltri*. The court first concluded it was bound by *Burke* to allow Hartford's three-year limitations period to begin running before Heimeshoff exhausted her administrative remedies:

> In this Circuit, a statute of limitations specified by an ERISA plan for bringing a claim under 29 U.S.C. §1132 may begin to run before a claimant can bring a legal action. *See Burke*, 572 F.3d at 81.
>
> Hartford's plan provided that its three-year limitations period ran from the time that proof of loss was due under the plan. The policy language is unambiguous and it does not offend the statute to have the limitations period begin to run before the claim accrues. *See id.*

Pet.App.3.

The court then held that under *Veltri*, Hartford was relieved of the minimum requirement in 29 C.F.R. § 2560.503-1(g)(1)(iv) to notify Heimeshoff, in its adverse determination letters, of the time limits for filing a civil action, because Hartford had provided Heimeshoff's counsel with a copy of the plan. The court equated providing the plan to a claimant's attorney with actual knowledge of Hartford's wasting limitations provision, and ruled Heimeshoff could not request equitable tolling

based on Hartford's inadequate notice. **Pet.App.4** (quoting *Veltri*, at 326). Accordingly, the court determined it did not need to address Hartford's failure to satisfy the regulation's notice requirements. The Second Circuit did not, therefore, require the insurer to meet the minimum notice regulations. *See* 29 C.F.R. §§ 2560.503-1(b)(2); (b)(3); (f)(3); (g); (h); (j).

The Second Circuit's decision allows ERISA plans and their fiduciaries to:

(1) Start the clock on the statute of limitations before the claimant has exhausted her administrative remedies and therefore before she could file any lawsuit:

(2) Avoid ERISA minimum regulations' requirement to notify the claimant in any adverse determination letter:

> (a) when the time limits for judicial review begin to run, as well as
>
> (b) the date when she must file her action (or lose the right to judicial review);

(3) Escape ERISA minimum regulations' requirement to notify the claimant of the time limits for judicial review in the SPD; and

(4) Escape ERISA's minimum notification requirements by simply giving the claimant's lawyer a copy of the plan.

B. Certiorari Is Warranted To Preserve Judicial Review, Denied By Circuits That Ignore ERISA Statutes, Regulations, And Higher-Than-Marketplace Standards For ERISA Fiduciaries.

The conflict among the circuits over accrual of ERISA statutes of limitations to deny judicial review, allows courts and ERISA plans to avoid ERISA's mandates, standards, minimum regulations, and basic purposes of statutes of limitations. Contrary to *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008), and the ERISA statute (29 U.S.C. § 1104 and 1001(b)(a)(1)) and regulations (29 C.F.R. § 2560.503-1; 29 C.F.R. § 2520.102-3(s), many courts have interpreted ERISA to allow plans to strip beneficiaries of their ability to file suit. *See, e.g., Burke v. PriceWaterHouseCoopers LLP Long Term Disability Plan*, 572 F.3d 76, 81 (2d Cir. 2009); *Rice v. Jefferson Pilot Fin. Ins. Co.*, 578 F.3d 450 (6th Cir. 2009); *Abena v. Metro. Life Ins. Co.*, 544 F.3d 880, 884 (7th Cir. 2008); *Blaske v. UNUM Life Ins. Co. of Am.*, 131 F.3d 763 (8th Cir. 1997); *Salisbury v. Hartford Life And Acc. Co.*, 583 F.3d 1245 (10th Cir. 2009). Setting an accrual time before denial, allowing the insurer to avoid telling the claimant the time limits for judicial review in the SPD or any adverse determination letter, and permitting the insurer to avoid notice regulations when the attorney has a copy of the plan, as the Second Circuit did here, individually or cumulatively, run counter to Congress's and the Court's purposes for ERISA by denying a claimant the right to judicial review. That right is critical for the protection of ERISA beneficiaries, as recognized by this Court and

expressly stated in the ERISA statute. *Varity Corp. v. Howe*, 516 U.S. 489, 513 (1996); 29 U.S.C. §§ 1001(b); 1104(a)(1).

In *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008), this Court noted that ERISA "permits a person denied benefits under an employee benefit plan **to challenge that denial in federal court**". *Id.* at 108 (emphasis added; citing 29 U.S.C. §1001 *et seq.*; §1132(a)(1)(B)). Based on Congress's intent and purposes in enacting ERISA, including the requirement to act **"solely in the interests of" plan participants and beneficiaries**, the Court in *Glenn* declared that insurers administering an ERISA plan are held to **higher-than-marketplace standards.** Explicitly stated in these standards is the ERISA fiduciary's duty to ensure that beneficiaries have ready access to federal courts:

> ERISA imposes higher-than-marketplace quality standards on insurers. It sets forth a special standard of care upon a plan administrator, namely, that the administrator "discharge [its] duties" in respect to discretionary claims processing "solely in the interests of the participants and beneficiaries" of the plan, §1104(a)(1); it simultaneously underscores the particular importance of accurate claims processing by insisting that administrators "provide a 'full and fair review' of claim denials," *Firestone [Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113,...(1989)](quoting §1133(2)); and it supplements marketplace and

> regulatory controls **with judicial review of individual claim denials,** *see* 29 U.S.C. §1132(a)(1)(B).

Id. at 115 (emphasis added).

Previously, *Varity Corp. v. Howe*, 516 U.S. 489, 513 (1996) acknowledged ERISA's stated objective of providing "'ready access to the Federal courts'" and expressed its disfavor with an interpretation of the statute that would strip beneficiaries of ability to file suit:

> ERISA's basic purposes favor a reading of the third subsection that provides the plaintiffs with a remedy. The statute itself says that it seeks
>
> > "to protect...the interests of participants ... and ... beneficiaries ... by establishing standards of conduct, responsibility, and obligation for fiduciaries ... and ... providing for appropriate remedies...and ready access to the Federal courts." ERISA §2(b).
>
> Section 404(a), in furtherance of this general objective, requires fiduciaries to discharge their duties "solely in the interest of the participants and beneficiaries." Given these objectives, it is hard to imagine why Congress would want to immunize breaches of fiduciary

> obligation that harm individuals by denying injured beneficiaries a remedy.

Id. at 513. Moreover, this Court has rejected a proposed accrual rule deemed "at odds with the basic policies of all limitations provisions: repose, elimination of stale claims, and **certainty about a plaintiff's opportunity for recovery and a defendant's potential liabilities.**" *Rotella v. Wood,* 528 U.S. 549, 555 (2000)(emphasis added).

ERISA's minimum regulations spell out the insurer's duty to inform beneficiaries about their right of judicial review, including time limits. The regulations requiring notice of the right to file an action were promulgated under Congress's mandate that ERISA employee benefit plans "provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied," 29 U.S.C. § 1133(1), and "afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review," *id.* § 1133(2).

This clear and specific mandate was part of Congress's response to the "lack of employee information and adequate safeguards concerning" the operation of these plans, which threatened the "continued well-being and security of millions of employees and their dependents." *Id.* § 1001(a). Through ERISA, Congress intended to "protect ... the interests of participants in employee benefit plans and their beneficiaries, by ... establishing standards of conduct, responsibility, and obligation for fiduciaries ... and by providing for appropriate

remedies, sanctions, and **ready access to the Federal courts**." *Id.* §1001(b) (emphasis added).

It is undisputed that Hartford did not notify Heimeshoff of the time limit for judicial review in any adverse determination letter or any other letter. This is required by **29 C.F.R. § 2560.503-1(g)(1)(iv) and (j)(4)**:

> **(g) Manner and content of notification of benefit determination.** (1) Except as provided in paragraph (g)(2) of this section, the plan administrator shall provide a claimant with written or electronic notification of any adverse benefit determination.... **The notification shall set forth, in a manner calculated to be understood by the claimant** –
>
> ...(iv) A description of the plan's **review procedures** and **the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action** under section 502(a) of the Act following an adverse benefit determination on review[.]
>
> * * *
>
> **(j) Manner and content of notification of benefit determination on review.** The plan administrator shall provide a claimant with written or electronic notification of a plan's benefit determination on review.... In the case of an adverse

> benefit determination, the notification shall set forth, in a manner calculated to be understood by the claimant –
>
> ... (4) A statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain the information about such procedures described in paragraph (c)(3)(iv) of this section, **and a statement of the claimant's right to bring an action** under section 502(a) of the Act[.]

(Emphasis added.)

It is also undisputed that Hartford did not provide the time limit for judicial review in the SPD. *See* 29 U.S.C. § 1022(a), (b)(listing information required in SPD); 29 C.F.R. § 2520.102-2(b); 29 C.F.R. § 2520.102-3(s) (plan must include in the SPD all claims procedures and time limits for appealing adverse benefit determinations).

C. Contrary to the Second and Other Circuits Following A Reasonableness Inquiry, The Fourth And Ninth Circuit's Rule Setting Accrual At Final Denial Provides A Bright Line Consistent With ERISA's Mandates and The Purposes of Statutes of Limitations.

1. The Fourth And Ninth Circuits Ensure Ready Access To Court By Setting Accrual At Final Denial.

The Fourth Circuit held in *White*:[14]

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[14] *See also Belrose v. Hartford*, 2012 U.S. App. LEXIS 7506 (4th

> [A] cause of action under ERISA for benefits does not accrue until a claim of benefits has been made and formally denied.... **This means that the statute of limitations begins to run at the moment when the plaintiff may seek judicial review, because ERISA plaintiffs must generally exhaust administrative remedies before seeking judicial review.**

Id. at 246 (emphasis added). Starting the limitations period before the claimant exhausted administrative remedies "flies in the face of the ERISA statutory framework." *Id.* at 246.

The Fourth Circuit refused to adopt a case-by-case, fact-intensive assessment of the reasonableness of the accrual provision, concluding this would immerse "courts in an extra-contractual and extra-statutory endeavor that is incompatible with ERISA's written-plan requirement." *Id.* at 246. Such an approach "would impose upon courts a federal common law methodology less compatible with the ERISA framework than the familiar accrual rule that federal courts have presumptively applied." *Id.* at 250. The reasonableness inquiry runs "counter to the values of certainty and predictability at the heart of most accrual and limitations rules", and is particularly incompatible with ERISA's "directive that plans makes the rights of their participants clear to nonlegal readers." *Id.* at 250 (citing 29 U.S.C. §1133(1)). Rather than enforcing plans "as written", "the opposite result obtains ... where the

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Cir. 2012)(confirming *White*'s rule).

interplay of accrual and limitations provisions and the tensions between internal and judicial review would only magnify the uncertainty that ERISA's framework of written instruments with clear rules and plain notice was designed to prevent." *Id.* at 253. The cases since *White* confirm this prediction of uncertainty and inconsistency.

White clearly articulated concerns that the Second Circuit in *Burke* later dismissed on the ground that the 2000 ERISA regulations would resolve them:[15] if allowed to start limitations periods running before the end of the administrative process, insurers would "write over the constraints established by federal law" by "starting the clock on its participants' claims before the participants can even file suit." *Id.* at 247. That is exactly what they have done through deliberate "plan design". Rumeld, **Pet.App.105**.

White held that the insurer's "accrual provision runs afoul of the statute's scheme of mutually reinforcing remedies by using the internal review mechanisms mandated by ERISA in a manner that **undermines and potentially eliminates the ERISA civil right of action."** *Id.* (emphasis added). **While internal appeals are "one cornerstone of ERISA[,]...judicial review is another".** *Id.* (citing 29 U.S.C. §1132(a); *Varity Corp. v. Howe*, 516 U.S. 489, 513 (1996)). These two remedies "must be interpreted in light of each other.... [C]ourts have universally found an exhaustion requirement in part because statutory text and structure establish **these twin remedies**

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[15] *Burke*, 572 F.3d at 80.

of administrative and judicial review as parts of a single scheme." *Id.* at 247 (emphasis added).

The *White* court quoted the very same notice regulation at issue here, 29 C.F.R. §2560.503-1(g)(1)(iv), as evidencing the "symbiotic nature of ERISA remedies" in that "[t]he civil action **is treated as an integral part of this review"** when the regulation requires the plan to provide the time limits for the plan's review procedures, including the right to bring a civil action. *Id.* at 247 n.2 (emphasis added). "This interlocking remedial structure does not permit an ERISA plan to start the clock ticking on civil claims while the plan is still considering internal appeals." *Id.* at 247.

> Benefit plans would have the incentive to delay the resolution of their participants' claims, because every day the plan took for its decision-making would be one day less that a claimant would have to review the plan's final decision, decide whether to challenge it in court, and prepare a civil action if need be. Indeed, a plan that did not reach a final decision until after the statute of limitations had run would deprive a participant of the right to file a civil claim at all. These incentives to delay would undermine internal appeals processes as mechanisms for "full and fair review," *see* 29 U.S.C. §1133(2), and **undermine the civil right of action as a complement to internal review,** *see Varity*, 516 U.S. at 513 (noting ERISA is designed to

> develop "a sensible administrative system").

Id. at 247-48 (emphasis added).

The case-by-case reasonableness approach does not reconcile internal and judicial review, but comes "at the expense of ERISA's 'written plan' and participant-notification requirements, as well as the values of notice and certainty that these requirements serve." *Id.* at 248-49. It requires courts to determine when the plan's compression of the limitations period is too severe and whether an accrual provision changes each day the plan does not issue a final decision. This approach does "not eliminate the perverse incentives to delay the resolution of claims." *Id.* at 248. Instead of informing participants of their rights, under the reasonableness method, the written plan misleads "claimants by setting forth a purported time limitation that would, in reality apply only if it satisfied a reasonableness analysis described nowhere in the plan." *Id.* at 249. It is a subjective standard, the application of which would shift over time, so that neither a participant "**nor even a court could determine**" when the cause of action would accrue. *Id.* (emphasis added).

White did not dispute plans' ability to set time limits for review, but its "quarrel" was "with the **lack of fair notice** to claimants" in the insurer's proposal. *Id.* at 250 (emphasis added). The case-by-case assessment also "lays waste to limitations periods' critical purpose of providing potential plaintiffs with **meaningful notice** of the timeliness of their actions and providing potential

defendants **an equally clear sense of when the time on possible claims has run.**" *Id.* at 251 (emphasis added).

All this remains true today and is manifested in the many cases addressing insurers' ongoing efforts to undermine the right of judicial review by setting accrual of contractual limitations provisions before benefits are finally denied.

White relied on the Ninth Circuit's decision in *Price v. Provident Life & Accident Ins. Co.*, 2 F.3d 986, 988 (9th Cir. 1993), where the court held a limitations provision accruing before administrative remedies were exhausted was unenforceable. The Ninth Circuit concluded "ERISA does not permit" the result in which the insurer simply buries a denial of coverage and wait for the statute of limitations to run. *See also Mogck v. Unum Life Ins. Co. of Am.*, 292 F.3d 1025, 1028-29 (9th Cir. 2002)(contractual limitation unenforceable because plan did not inform beneficiary in denial, with policy language, that contractual time limitation would begin to run; not deciding whether California regulations required insurer to inform claimant of contractual limitations period). As the court held in *Wise v. Verizon Communications, Inc.*, 600 F.3d 1180 (9th Cir. 2010):

> [T]here is no reason to think that Congress wanted ERISA benefits-recovery suits to be bogged down by collateral litigation over the applicable statute of limitations.... Avoiding procedural uncertainty helps every actor in a benefits-recovery action: the

> plaintiff, the plan defendant, and the court adjudicating the claim. **All benefit from having a bright line rule on the necessary procedures for claims.**

Id. at 1185-86 (emphasis added; discussing *Wilson v. Garcia*, 471 U.S. 261, 266-67 (1985),[16] choosing one limitations period applicable to 29 U.S.C. §1132(a)(1)(B) actions in each state).

District courts in the First,[17] Third, and Eleventh Circuits agree with the Fourth and Ninth Circuits, confirming their reasoning in recent decisions. *See, e.g., Tuttle v. Cigna Group Ins.*, 2011 U.S.Dist.LEXIS 77987, at *6-7 (S.D.Miss. July 18, 2011)(summarizing cases). In *Whittaker v. Hartford Life Ins. Co.*, 2012 U.S. Dist. LEXIS 166983 (E.D. Pa. Nov. 25, 2012), based on the same Hartford limitations provision involved here, noting the Third Circuit had not decided whether a claim could accrue before the claimant exhausted his remedies,[18] the court chose the final termination letter as the accrual date.

Whittaker held "it would be unfair and inequitable to hold Plaintiff to any disadvantage

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[16] *Superseded by statute on other grounds*, Pub. L. No. 101-650, 104 Stat. 5089, 5114-15 (1990).

[17] *Island View Residential Treatment Ctr., Inc. v. Bluecross Blueshield of Mass., Inc.*, 2007 U.S.Dist.LEXIS 94901, at *43 (D.Mass. Dec. 28, 2007), *aff'd*, 548 F.3d 24 (1st Cir. 2008)(setting accrual at plan's final denial of the claimants' administrative appeals, "despite the contractual language", noting this made "sense from a policy perspective as well").

[18] Citing *Rumpf v. Metro. Life Ins. Co.*, Civ. A. No. 09-557, 2010 U.S.Dist. LEXIS 74388 (E.D. Pa. July 23, 2010).

because she followed the instructions in the letter she received...denying her benefits .... [I]t would be a miscarriage of justice to find that the accrual date started any earlier than" the date on which the plaintiff's appeal was denied. *Id.* Likewise, in *Whittaker,* as here, Hartford's denial letters stated, "After your appeal, and if we again deny your claim, you then have the right to bring a civil action under Section 502(a) of ERISA." The court adopted the date of the final appeal denial for accrual, noting that had the claimant filed before her administrative appeal was denied, her case would have been dismissed:

> To start the running of the limitations period before the conclusion of the administrative appeals process would encourage plan administrators to drag their feet in deciding administrative appeals so as to minimize the amount of time a plaintiff has to prepare her case."

Id. at *20-22.

While the Eleventh Circuit "has not directly answered the question whether the limitations period is triggered by the date of proof of loss or the date of the final claims decision" it has required exhaustion of administrative remedies. *Amos v. Hartford Life & Accident Ins. Co.,* 2009 U.S.Dist.LEXIS 53287, at *3-4 (N.D.Ala. June 24, 2009). Following *White,* the court held "'Common sense and basic fairness dictates [sic] that **if we are willing to read in an exhaustion requirement, we must toll the limitations period while exhaustion occurs.**'" *Id.* at *5-6 (emphasis added;

quoting *Jeffries v. Trustees of Northrop Grumman Savings & Inv. Plan*, 169 F.Supp.2d 1380, 1382 (M.D.Ga. 2001)). *See also Zorn v. Principal Life Ins. Co.*, 2012 U.S.Dist.LEXIS 3833,at *29-30 (S.D.Ga. Jan. 12, 2012)("Courts in this Circuit dealing with contractual limitations periods for §1132(a)(1)(B) claims have determined that limitations periods are tolled until the end of an administrative review process.")

2. The Second, Sixth, Seventh, Eighth, Tenth Circuits' Case-By-Case Reasonableness Approach Allows Plans To Undermine Judicial Review.

Among the circuits using the reasonableness inquiry--the **Second, Sixth, Seventh, Eighth and Tenth Circuits**[19]– many courts (apart from *Burke*) nevertheless recognize the "procedural quagmire"[20]

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[19] The Fifth Circuit in *Baptist Mem. Hosp.- Desoto, Inc. v. Crain Auto., Inc.*, 392 Fed.Appx. 289 (5th Cir. 2010). **corrected** the *Burke* court's erroneous assumption that it had "joined" the courts disagreeing with the Fourth and held that an administrator cannot assert a shorter-than-statutory limitations period when it fails to comply with procedural obligations. *Id.* at 295-96.

[20] In *Wolfe v. 3M Short-Term Disability Plan*, 176 F.Supp.2d 911, 916-19 (D.Minn. 2001), the court invoked equitable tolling while the claimant exhausted administrative remedies, recognizing "the procedural quagmire" that confronts a claimant who is forced to pursue internal administrative processes "if tolling is not applied":

> If a plaintiff files her complaint to avoid the running of the limitations period but prior to fully exhausting her internal remedies, she risks dismissal of her claim for failure to exhaust her administrative remedies.

resulting from allowing the limitations period to run out before the claimant can file suit.

While the Second Circuit in this case determined it was bound by *Burke*, the parties did not raise in *Burke* the minimum notice regulations involved in this case, and the court did not address them. Moreover, *Burke*, though issued in 2009, did not cite *Glenn* and ignored *Glenn*'s requirement of higher-than-marketplace standards for ERISA insurers.

Both the district court and court of appeal in *Burke* articulated the concern that an "insurer [could] simply bury a denial of coverage and wait for the statute of limitations to run." *Burke*, 537 F.Supp.2d at 550 (quoting *Price*, 2 F.3d at 988). The courts also noted the possibility that a plan administrator would use the administrative process to undermine and potentially eliminate the ERISA civil right of action; and could "eat up the entire limitations period" even under the 2000 regulations. *Burke*, 537 F.Supp.2d at 550 (citing *White*, 488 F.3d at 247, 251); *Burke*, 572 F.3d at 80. But the court concluded that the Department of Labor's regulations issued in 2000 would alleviate those concerns: "The time remaining after the administrative appeal process has run its course under the DOL regulations, as well as the protections provided should the plan administrator

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> Conversely, a plaintiff who exhausts her internal remedies as required under the plan itself, ERISA and applicable caselaw, there is a risk that, absent tolling, the limitations period will expire before she files suit in federal court.

Id. at 918.

be dilatory, support enforcing the contractual limitations provision in this case." *Burke,* 572 F.3d at 80.

Unfortunately, the regulations did not remove the incentives insurers have to delay resolution of a claim while limitations periods tied to proof of loss are wasting. The pre-appeal period still is counted against a claimant who requires time to obtain relevant or additional materials and present an appeal. The plan can still drag the time out: "by requesting more information for its determination, a plan can toll time constraints that the regulations impose on its consideration, even as the limitations period in the plan document would continue to run against the claimant....The regulations ... thus fail to alleviate the concerns we have expressed regarding incentive effects, constantly shifting time periods, the absence of fair notice to all parties, and the continual tension between internal appeals and judicial review." *White,* 488 F.3d at 252.

The real solution holds insurers to the minimum regulations requiring them to notify claimants in the adverse determination letters and the SPD of the time limits for judicial review, including when the period begins to run and how much time remains, regardless of whether or not an attorney is involved.

Even under the reasonableness approach, the **Eighth Circuit** declined to allow Hartford's wasting limitations provision (three years after proof of loss was required to be furnished) to begin running before formal denial or clear repudiation made known to the beneficiary. *Wilkins v. Hartford Life &*

Accident Ins. Co., 299 F.3d 945, 948-49 (8th Cir. 2002).

Similarly, the **Tenth Circuit,** in *Salisbury v. Hartford Life & Accident Ins. Co.*, 583 F.3d 1245, 1249 (10th Cir. 2009), acknowledged the tension with the exhaustion requirement:

> Less drastic remedies that would take account of both the Plan's right to set a limitations period and the claimant's need to exhaust administrative remedies would be to allow a claimant at least a reasonable time after exhaustion of administrative remedies or to apply equitable tolling during the pendency of the administrative review process.

Id. at 1249 (citing *Wilkins*, at 949 (8th Cir.) and *Doe v. Blue Cross & Blue Shield United of Wis.*, 112 F.3d 869, 876 (7th Cir. 1997)(if defendant "through representations or otherwise prevents the plaintiff from suing within the limitations period, the plaintiff may add to the remaining limitations period the entire period during which the defendant's action was effective in delaying the suit."))

These cases, however, do not enforce the regulations' notice requirements, *see Novick v. Metro. Life Ins. Co.*, 764 F.Supp.2d 653 (S.D.N.Y. 2011), and they do not create a bright line for determining accrual of the statute of limitation for potential litigants.

3. Courts Have Reconciled the Tension Between Exhaustion And Pre-Denial Accrual By Holding Insurers To ERISA's Notice Requirements.

This Court has observed:

> While it is theoretically possible for a statute to create a cause of action that accrues at one time for the purpose of calculating when the statute of limitations begins to run, but at another time for the purpose of bringing suit, we will not infer such an odd result in the absence of any such indication in the statute.

Reiter v. Cooper, 507 U.S. 258, 267 (1993). ERISA statutes do not indicate any reason to infer the odd result created and perpetuated by ERISA insurers. This Court's guidance is needed to arrest the erosion of claimants' right to judicial review.

Insurers' failure to disclose time limits for judicial review must be viewed in light of the regulatory notice requirement and Congress's policy of protecting the interests of plan participants by ensuring "disclosure and reporting to participants" and "ready access to the Federal courts." 29 U.S.C. § 1001(b). The notice regulation assumes that a reasonable beneficiary would not otherwise be aware that she has the right to file a court action to review her benefits denial. The congressional policy favors placing the burden of disclosure on plans and exercising caution before closing the courthouse door. Failure to comply with the regulatory obligation to disclose the existence of a cause of

action to the plan participant whose benefits have been denied is tantamount to the type of concealment that has led some courts to equitably toll the statute of limitations. *See Veltri*, 393 F.3d at 318.

Why would insurers resist the seemingly straightforward step of notifying claimants of the time limits? ERISA defense counsel candidly admit that insurers choose to "protect the plan" over the Congressional mandate to act solely in the interests of beneficiaries. *See* Rumeld, **Pet.App.105-112**. *See also* Reuter, **Pet.App.97-104**; Begos, **Pet.App.90-96**.[21]

The remedy adopted in *Novick* and *Ortega Candelaria* resolves the tension between ERISA's exhaustion requirement and permits insurers to draft the limitations provisions they desire, so long as they tell beneficiaries when the time to file a judicial action runs out. If insurers do not follow the regulations, they cannot assert the statute of limitations defense.

Novick simply and logically applied ERISA's minimum notice regulations to require that the insurer inform the beneficiary, in the adverse determination letters and the SPD, of the time limits for filing an action in court. Integral to *Novick* is the court's holding that a civil action under 29 U.S.C. §1132(a) is part of the plan's review procedures, such that the regulations require the plan to notify the claimant of the time limits for judicial review: "the applicable regulations and the Plan itself make a

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[21] Hartford's counsel admitted it was possible to give notice of time limits for judicial review. **Pet.App.40.**

claimant's ability to seek judicial review part of such procedures; and, therefore,... disclosure of the applicable time limit is required." *Id.* at 661 (discussing *Chappel v. Laboratory Corp. of America*, 232 F.3d 719 (9th Cir. 2000)).[22]

The *Novick* court supplied overwhelming authority for this remedy. *Novick* employed statutory construction of the "plain", "unambiguous" ERISA minimum regulations, §2560.503-1(g) and (j), *id.* at 660-61, reading them together with:

- Congress's desire in ERISA to permit plans to establish the limitations period for judicial review themselves (instead of by law), *id.* at 661;
- Support from the Ninth and Fourth Circuits;
- The SPD's statement of the contractual limitations period in the same section of the plan including judicial review, *id.* at

---

[22] *Chappel* held that post-denial arbitration of ERISA claims was part of the "plan's review procedures" such that the insurer was required to give the claimant written notice of the "steps to be taken to obtain external review". *Id.* at 726-27 (based on regulations before those currently effective).

> **It would have been a simple matter, when the Plan administrator sent a letter to Chappel notifying him of its denial of his appeal, for the administrator to have notified Chappel in that same letter of the arbitration clause and its required procedures.**

(Emphasis added.)

In the present case, Hartford's counsel admitted the plan could have given notice of the time limits for judicial review. **Pet.App.40**.

662;

- The ERISA statutory scheme as a whole; and
- Significant secondary sources recommending that plans include stated time limitations for bringing suit in all claim and claim appeal determinations, *id.* at 663.

By mandating that plans notify the claimant of the limitations deadline in the denial letter, "the court imposed a simple rule that would have eliminated several recent appellate rulings on contested limitations periods because the accrual of the limitations period was confusing." Mark D. DeBofsky, *Courts struggle with when limitation periods accrue*, Daley DeBofsky & Bryant (March 21, 2011), www.ddbchicago.com/articles-and-archives/articles- by-mark-d-debofsky/courts-struggle. **Pet.App.113.** The author notes the clarity of *Novick*'s approach, as statutes of limitations are supposed to work:

> Even if the wrong date is communicated, so long as the plaintiff files suit prior to when the plan asserts the limitations period would expire, no plaintiff will be barred from proceeding with his or her claim. Such a rule would avoid the situations that occurred in several recent appellate rulings.

Id.

Novick contrasts with the cases rejecting

White and those adopting the case-by-case reasonableness approach. *See, e.g., Burke; Abena v. Metropolitan Life Ins. Co.*, 544 F.3d 880 (7th Cir. 2008).

> Given such inconsistency, and on account of the risk of uncertainty as to the accrual of the limitations period posed by the cases cited above, *Novick* is a particularly instructive ruling in its holding that the communication of the date the limitations period would expire leaves no doubt as to the parties' rights.

Id.

In this regard, at oral argument, Hartford's counsel conceded that Hartford could have notified Heimeshoff of the time limits for judicial review:

> THE COURT 3: So what you're saying is there might be some instances, not here, where the three years will run from the denial.... Nobody's going to worry about those folks.
>
> The point is, in a lot of places ... it begins running a lot earlier, like here, two years earlier, and don't you think as a matter of fairness the policy holder ought to know that, a noncounseled policy holder?
>
> MR. BEGOS: ... [W]hat I would say is that **a claim administrator certainly could make that type of disclosure on a voluntary basis,** but

> it's not required by the regulations, and I think the --
>
> THE COURT 3: Unless the text of this regulation reads -- is read to mean what it says.

Pet.App.40-41. If they could give notice, why did they not give notice?

The text does mean what it says. In the regulation, the word "including" in subsection (g) follows a comma after directing the plan to provide both a description of the plan's review procedures and the "time limits" applicable to those procedures. This means the requirement to disclose "the claimant's right to bring a civil action" modifies, at a minimum, the antecedent "time limits". And because the regulation is in the conjunctive ("and"), it also modifies the plan's review procedures, of which the right to bring a civil action is "includ[ed]".

"[W]here several words are followed by a general expression ... which is as much applicable to the first and other words as to the last, that expression is not limited to the last, but applies to all." *United States v. Standard Brewery, Inc.*, 251 U.S. 210, 218 (1920)(quotation omitted). The legislative history fully supports this construction, since the DOL's comments to the 2000 regulations (above) make clear that ERISA guarantees the right of judicial review.

In *Ortega Candelaria*, the court also read the regulation in this way, rejecting in dictum the construction urged by Hartford and adopted by the District Court in this case:

> [I]t could be argued that notice of the right

> to sue under ERISA is in addition to, and divorced from, notice of review procedures and the time frame pertaining to such procedures....We think it clear that the term "including" indicates that an ERISA action is considered one of the "review procedures" and thus notice of the time limit must be provided.

661 F.3d at 680 n.7.

Four recent articles by ERISA practitioners (including Hartford's counsel) further demonstrate the need for this Court's review and articulation of a uniform accrual rule:

(1) Mark D. DeBofsky, *Courts struggle with when limitation periods accrue*, Daley DeBofsky & Bryant (March 21, 2011), www.ddbchicago.com/articles-and-archives/articles-by-mark-d-debofsky/courts-struggle/. **Pet.App.113.**

(2) Patrick Begos, *Statute of Limitations Can Start Running Before Claim Accrues*, ERISA Claim Defense Blog (Sept. 24, 2012), www.erisaclaimdefense.com/statute-of-limitations-can-start-running-before-claim-accrues/, **Pet.App.90**.

(3) Myron D. Rumeld, Russell L. Hirschhorn and Brian Neulander, *ERISA's Statute of Limitations for Benefit Claims: Where To Begin?*, The ERISA Litigation Newsletter (July 2010), http://www.proskauer.com/publications/newsletters/erisa-litigation-newsletter-july-2010/. **Pet.App.105**.

(4) Aaron A. Reuter, *Limiting ERISA's Limitations Period Through the Use of Contractual*

Accrual Dates, The ERISA Litigation Newsletter (April 2012), http://www.proskauer.com/publications/newsletters/erisa-litigation-newsletter-april-2012/. **Pet.App.97**.

Begos (Hartford's counsel) broadly states: "in many circuits, the statute of limitations clock can begin to run well before administrative remedies are exhausted"; omitting the Ninth Circuit's consistency with the Fourth Circuit's approach in *White*. *Cf.* Reuter (Ninth Circuit is aligned with the Fourth Circuit; both refuse "to enforce accrual provisions derived from ERISA plan statute of limitations language" and "instead apply the 'clear repudiation rule.'")

Reuter describes the conflict as dividing over whether to apply federal common law to decide the time of accrual, instead of honoring the contractual language in its entirety: "the federal discovery rule...can require plans to defend the merits of dated claims." Reuter advocates for a rule allowing plans to eviscerate statutes of limitation on the right to judicial review and create variable, non-uniform results. He concludes the reasonableness approach "is more consistent with the enforcement of the contractual provisions of ERISA plans because these courts allow for the adoption of *both* reasonable temporal lengths and accrual dates for statute of limitations purposes."

> It seems illogical to only adopt one half of the provision; indeed, how can the reasonableness of a time period be established without considering when it starts?

> While the *Miller* [*v. Fortis Benefits Ins. Co.*, 475 F.3d 516 (3d Cir. 2007)] decision seems to follow the reasoning of the **Fourth and Ninth Circuits**, its decision in *Klimowicz [v. Unum Life Insurance Co. of America* 296 Fed. Appx. 248 (3d Cir. 2008)] appears to find a middle ground. Where a contractual accrual provision is either unreasonable or not available, it makes sense to utilize the clear repudiation rule. Where, however, there is a reasonable contractual accrual provision, it should be adopted and applied along with the rest of the contractual statute of limitations provision.

(Emphasis added; footnotes omitted.)

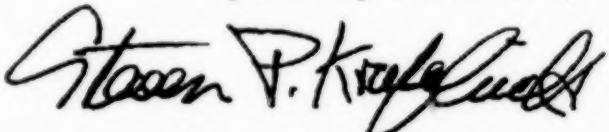
Reuter and Begos are attorneys representing ERISA plans and their insurers. They both recognize the conflict among the circuits and urge strict construction of the contracts. However, they ignore basic ERISA requirements set out in the statute, regulations, and Supreme Court precedent. DeBofsky, a plaintiff's attorney, concurs that a circuit conflict exists and explains the need to enforce the ERISA regulations. **Pet.App.113.**

CONCLUSION

Petitioner Julie Heimeshoff prays that this Court issue a Writ of Certiorari to the United States Court of Appeals for the Second Circuit to resolve the conflict in the circuits over when ERISA statutes of limitation accrue. This has been a growing problem which the circuits have addressed in three different ways: (1) a bright-line rule setting accrual at final denial; (2) a case-by-case inquiry to determine the reasonableness of a contractual pre-denial statute of limitations; and (3) requiring notice of the plan's time limits for judicial review, in the SPD and adverse benefit determinations.

No bright line exists for accrual of statute of limitations in ERISA cases though one is sorely needed. The remedy for this conflict is to enforce higher-than-marketplace standards, *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105, 115 (2008), protect access to judicial review, *Varity Corp. v. Howe*, 516 U.S. 489, 513 (1996); 29 U.S.C. §§ 1001(b), and require plans to notify claimants of the time limits for judicial review in adverse determination letters and the SPD. *See* 29 C.F.R. §§ 2520.102-2(b), 2520.102-3(s); 2560.503-1(b)(2); (b)(3); (f)(3); (g); (h); (j).

Respectfully submitted,



Steven P. Krafchick,
Counsel of Record
Carla Tachau Lawrence,
Attorneys for Petitioner

APPENDIX

RECORD
AND
BRIEFS

Supreme Court, U.S.
FILED
DEC 11 2012
OFFICE OF THE CLERK

12 No 729

In The
Supreme Court of the United States

JULIE HEIMESHOFF,

Petitioner,

v.

HARTFORD LIFE & ACCIDENT INSURANCE CO., and WAL-MART STORES, INC.,

Respondents.

ON PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES
COURT OF APPEALS
FOR THE NINTH CIRCUIT

APPENDIX TO THE PETITION FOR WRIT OF CERTIORARI

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UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

PRESENT: BARRINGTON D. PARKER,
RICHARD C. WESLEY,
Circuit Judges,
JOHN GLEESON,
District Judge.*

*The Honorable John Gleeson, of the United States District Court for the Eastern District of New York, sitting by designation.

JULIE HEIMESHOFF,

Plaintiff-Appellant,

v.

HARTFORD LIFE & ACCIDENT INSURANCE CO. AND WALMART STORES,

Defendants-Appellees.

No. 12-651-cv

SUMMARY ORDER
Filed September 13, 2012

FOR APPELLANT: STEVEN P. KRAFCHICK,
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FOR APPELLEES: PATRICK W. BEGOS,
Begos Horgan & Brown LLP,
Southport, CT. 567

Appeal from the United States District Court for the District of Connecticut (Arterton, J.).

UPON DUE CONSIDERATION, IT IS HEREBY ORDERED, ADJUDGED AND DECREED that the judgment of the United States District Court for the District of Connecticut is **AFFIRMED**.

Julie Heimeshoff appeals from a judgment of the United States District Court for the District of Connecticut (Arterton, *J.*), granting Appellees' motion to dismiss Appellant's 29 U.S.C. § 1132(a)(1)(B) action challenging Hartford Life & Accident Insurance Company's ("Hartford") denial of long-term disability benefits under ERISA. The district court dismissed Appellant's claim as untimely because Appellant filed her action outside of the policy prescribed three-year statute of limitations period. We assume the parties' familiarity with the underlying facts, the procedural history, and the issues presented for review.

This Court reviews *de novo* a district court's grant of a motion to dismiss. *See Guilbert v. Gardner*, 480 F.3d 140, 27 145 (2d Cir. 2007). Section 1132 creates a cause of action for beneficiaries of an ERISA plan to "recover benefits . . . to enforce [] rights . . . or to clarify [] rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). ERISA does not contain a specific limitations period for challenging the denial of benefits. *See Burke v. PriceWaterHouseCoopers LLP Long Term Disability*

Plan, 572 F.3d 76, 78 (2d Cir. 2009). Instead, the controlling limitations period is provided by the "most nearly analogous state limitations statute." *See id.*

Appellant makes two arguments for why her claim was not time-barred.

First, Appellant argues that Hartford's contractual limitations period did not begin to run until the final denial of benefits. Here, Connecticut's six-year statute of limitations applicable to contract actions applies, Conn.Gen.Stat. § 52-576, while federal law controls the accrual date of the party's claim. *See Guilbert*, 480 F.3d 18 at 149. Under Connecticut law, parties to an insurance contract may shorten the statute of limitations period to not less than one year. *See* Conn.Gen.Stat. § 38a-290. In this Circuit, a statute of limitations specified by an ERISA plan for bringing a claim under 29 U.S.C. § 1132 may begin to run before a claimant can bring a legal action. *See* 2 *Burke*, 572 F.3d at 81.

Hartford's plan provided that its three-year limitations period ran from the time that proof of loss was due under the plan. The policy language is unambiguous and it does not offend the statute to have the limitations period begin to run before the claim accrues. *See id.* Appellant filed her claim challenging the denial of long term disability benefits more than three years after her proof of loss was due. Therefore, Appellant's action is time-barred.

Second, Heimeshoff argues that Hartford was required to disclose the time limits for filing a civil action in its denial of benefits letters pursuant to 29 C.F.R. § 15 2560.503–1(g)(1)(iv). Appellant contends that Hartford's failure to do so entitles Appellant to equitable tolling of her claim. Appellant relies upon a case from the Southern District of New York to support its claim that the regulation in question requires notice. *See Novick v. Metropolitan Life Ins. Co.*, 764 F. Supp. 2d 653, 660-64 (S.D.N.Y. 2011). We need not address this issue. Appellant's counsel conceded in the district court and at oral argument that he had received a copy of the plan containing the unambiguous limitations provision long before the three-year period for Appellant to bring the claim had expired. Thus, Appellant is not entitled to equitable tolling. *See Veltri v. Building Service 32B-J Pension Fund*, 393 F.3d 318, 326 (2d Cir. 2004) ("a plaintiff who has actual knowledge of the right to bring a judicial action challenging the denial of her benefits may not rely on equitable tolling notwithstanding inadequate notice from her pension plan").

For the foregoing reasons, the judgment of the district court is hereby **AFFIRMED**.

FOR THE COURT:
Catherine O'Hagan Wolfe, Clerk
United States Court of Appeals,
Second Circuit

s/ Catherine O'Hagan Wolfe

UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

Julie Heimeshoff,

Plaintiff,

v.

Hartford Life & Accident Insurance Co. and Wal–Mart Stores Inc.,

Defendants.

Civil No. 3:10cv1813 (JBA)

RULING ON DEFENDANTS' MOTION TO DISMISS

Filed January 20, 2012

On November 18, 2010, Plaintiff Julie Heimeshoff filed a Complaint against Defendants Hartford Life and Accident Insurance Company ("Hartford") and Wal–Mart Stores, Inc. ("Wal–Mart"), claiming Defendants violated the provisions of the Employee Retirement Income Security Act ("ERISA") by failing to provide long–term disability benefits to which she was entitled under the employee benefit plan issued by Defendants. Defendants move [Doc. # 29] to dismiss the Complaint, arguing that it is time–barred under the terms of the employee benefit plan. For the reasons

that follow, Defendants' motion to dismiss will be granted.

I. Factual Background

A. Plaintiff's Allegations

Ms. Heimeshoff alleges as follows in her Complaint. She worked for Wal–Mart from April 29, 1986 to June 8, 2005, holding the position of Senior Public Relations Manager at the time she left Wal–Mart. (Compl. [Doc. # 1] ¶¶ 11, 15.) During her time at Wal–Mart, she became eligible for its Group Long Term Disability Plan for Employees ("Plan"), administered by Hartfor (*Id.* ¶¶ 6, 12.) In January 2005, she began suffering from pain and fatigue due to fibromyalgia; she also suffered from chronic pain, "likely Irritable Bowel Syndrome and possible Restless Leg Syndrome, Allergies, and strong past history of lupus," and in May 2005 her "pain, fatigue, and other disabling symptoms increased." (*Id.* ¶¶ 13–14.) Ms. Heimeshoff "tried to continue working despite her medical conditions," but "due to her significant pain, extreme fatigue, and cognitive impairment, she had to stop working on or about June 8, 2005," and has since been unable to sustain full–time employment due to her conditions. (*Id.* ¶¶ 15–16.)

Ms. Heimeshoff further alleges that she meets the definition of "total disability" contained in the Plan, which reads:

> Total Disability or Totally Disabled means You are prevented from performing the Essential Duties of:
>
> 1) Your Occupation or a Reasonable Alternative Job offered to You by the Employer during the Elimination Period and for the 12 months following the Elimination Period, and as a result Your Current Monthly Earnings are less than 20% of Your Pre-disability Earnings; and
>
> 2) after that, Any Occupation

(*Id.* ¶¶ 18–20.) Hartford sent her a letter dated August 19, 2005 which stated: "Our records indicate that your disability may extend beyond the 90 day Salary Continuation period. In order to determine your eligibility for Long Term Disability (LTD) benefits, please complete and return the enclosed Group Claim forms." (*Id.* ¶ 21.) On August 22, 2005, Ms. Heimeshoff filed a claim for LTD benefits with Hartford, "listing extreme fatigue, significant pain, and difficulty in concentration," and supported by an Attending Physician Statement by her rheumatologist, Dr. Michael Saitta, with a diagnosis of Systemic Lupus Erythematosis ("SLE") and fibromyalgia. (*Id.* ¶¶ 22–23.)

On November 29, 2005, Hartford notified Mr. Heimeshoff via letter that it had not received a response from Dr. Saitta regarding her functionality, that it therefore could not make a claim determination, but that if it received that information it expected to make a claim decision

within 30 days. (*Id.* ¶¶ 26–27.) By letter dated December 8, 2005, Hartford denied Ms. Heimeshoff's claim for LTD benefits for failure to "provide satisfactory Proof of Loss," citing a lack of response from Dr. Saitta and advising her that if she "would like this information considered, we must receive it as soon as possible." (*Id.* ¶ 28.) Ms. Heimeshoff obtained counsel in May 2006 "to assist her in acquiring the 'satisfactory Proof of Loss' the Hartford was requesting," and was informed by Hartford "that no formal appeal was necessary and that if Hartford received clarification of Ms. Heimeshoff's functionality, they would re–open the claim." (*Id.* ¶¶ 29–30.)

Ms. Heimeshoff underwent "a two–day Performance–Based Physical Capacity Evaluation ("PCE") on July 18 and 19, 2006" to provide Hartford with the requested functionality information, after which Dr. Becker concluded that "[t]he deficits identified in the objective testing and physiological screening shows application barriers which will negatively [a]ffect vocational options, avocational interests, and options undertaken in quality of life functions." (*Id.* ¶ 32.) Dr. Becker further concluded: "The physiological profiles show that the examinee should be considered work intolerant. The physiological response shows that competitive and predictable sustained work is absent for all levels of category according to the Dictionary of Occupational Titles." (*Id.*) On October 2, 2006, Ms. Heimeshoff's counsel forwarded Dr. Becker's PCE to Hartford, along with a report from her primary treating physician, Dr. Stephen Goss, confirming her disability. (*Id.* ¶¶ 34–35.)

Hartford retained Dr. Norman Bress, a rheumatology consultant, who reviewed the PCE and spoke with Dr. Saitta, and issued a report on November 20, 2006 concluding that Ms. Heimeshoff "was able to perform the activities of her sedentary occupation." (*Id.* ¶¶ 36–38.) On November 29, 2006, Hartford denied Ms. Heimeshoff's claim. (*Id.*¶ 39.) On September 26, 2007, she appealed the denial, relying on the conclusions of Drs. Becker, Goss, and Saitta, along with a Cardiopulmonary Exercise Evaluation by Dr. VanNess and a neuropsychological evaluation by Dr. Sheila Bastien. (*Id.* ¶¶ 40–44.) Dr. Tanya Lumpkins, retained by Hartford, concluded after reviewing her records, that "[t]here is no support in the records that the claimant would not tolerate, with adequate effort and training, a work hardening program to improve conditioning, and thereby work capacity." (*Id.* ¶ 45.) Dr. Alexander Chervinsky, also retained by Hartford, concluded that "[i]nfluences of medication, emotional problems, or motivation for secondary gain may account for the findings." (*Id.* ¶ 46.)

Ms. Heimeshoff alleges that Hartford issued "its last and final denial letter" on November 26, 2007. (*Id.* ¶ 47.)

B. Plan Deadlines

Under the Plan, if a claim is approved, benefits become payable after an Elimination Period—the period an employee must be totally disabled before benefits become payable—of 90 days, or the end of Wal–Mart's salary continuation payments, whichever is longer. (Policy, Ex. A to

Begos Decl. [Doc. # 28] at 000011–13.) The Plan policy also requires that "[w]ritten proof of loss must be sent to The Hartford within 90 days after the start of the period for which The Hartford owes payment. After that, The Hartford may require further written proof that you are still Disabled." (*Id.* at 000027.) The Plan policy also provides that "[l]egal action cannot be taken against The Hartford . . . after the shortest period allowed by the laws of the state where the policy is delivered. This is 3 years after the time written proof of loss is required to be furnished according to the terms of the policy." (*Id.* at 000029.)

II. Applicable Legal Standard

Plaintiff argues that because Defendants raise an affirmative statute of limitations defense in their motion and rely on materials outside the Complaint—the Plan policy and the Administrative Record of Ms. Heimeshoff's claim for benefits—the Court should treat Defendants' motion to dismiss as a motion for summary judgment pursuant to Federal Rule of Civil Procedure 56. (Opp'n [Doc. # 30] at 13–15.) Defendants argue that because Ms. Heimeshoff expressly incorporates the Plan policy and the claim file into her Complaint, the Court may therefore consider these written instruments in deciding the motion to dismiss without treating the motion as a motion for summary judgment. (Reply [Doc. # 37] at 1–2.)

Federal Rule of Civil Procedure 12(d) provides: "If, on a motion under Rule 12(b)(6) or 12(c), matters outside the pleadings are presented to

and not excluded by the court, the motion must be treated as one for summary judgment under Rule 56." However, pursuant to Rule 10(c),[1] a complaint "is deemed to include any written instrument attached to it as an exhibit or any statements or documents incorporated in it by reference." *Cortec Indus., Inc. v. Sum Holding L.P.*, 949 F.2d 42, 47 (2d Cir. 1991). Accordingly, "[i]n determining the adequacy of the complaint, the court may consider any written instrument attached to the complaint as an exhibit or incorporated in the complaint by reference, as well as documents upon which the complaint relies and which are integral to the complaint." *Subaru Distrib. Corp. v. Subaru of Am., Inc.*, 425 F.3d 119, 122 (2d Cir. 2005). In ruling on a Rule 12(b)(6) motion, the Court may consider materials incorporated by reference and integral to a complaint notwithstanding the Rule 12 conversion requirement. *Global Network Commc'n, Inc. v. City of New York*, 458 F.3d 150, 156 (2d Cir. 2006) (citing *Cortec*, 949 F.2d at 47–48).

Plaintiff's Complaint expressly incorporates the documents relied on by Defendants in their motion to dismiss, stating: "Ms. Heimeshoff incorporates the entirety of the claim file Hartford produced in connection with her claim for long–term disability benefits as if annexed hereto." (Compl. ¶ 5 n.1.) Throughout her Complaint, Ms. Heimeshoff

---

[1] Rule 10(c) reads: "A statement in a pleading may be adopted by reference elsewhere in the same pleading or in any other pleading or motion. A copy of a written instrument that is an exhibit to a pleading is a part of the pleading for all purposes."

cites to portions of the Plan policy and the administrative record. (*See id.* ¶¶ 11–15, 18, 21–33, 35–47.) The Plan policy incorporated and cited by Ms. Heimeshoff in her Complaint includes the limitations period upon which Defendants rely (*see* Policy at 000029) and she includes in her Complaint the dates relevant to Defendants untimeliness argument, including the date from which she was unable to work, June 8, 2005 (Compl. ¶ 15) and the date from which she demanded benefits, June 7, 2005 (*id.* ¶ 81). The Court will therefore consider Defendants' untimeliness argument on their motion to dismiss, will consider the Plan policy and claim record expressly incorporated in Complaint, and will not convert Defendants' motion to dismiss into a motion for summary judgment.

Pursuant to Rule 12(b)(6) of the Federal Rules of Civil Procedure, "[t]o survive a motion to dismiss, a complaint must contain sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.'" *Ashcroft v. Iqbal*, 129 S. Ct. 1937, 1949 (2009) (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007)); *accord Kuck v. Danaher*, 600 F.3d 159, 162–63 (2d Cir. 2010). A complaint will not survive a motion to dismiss if it relies on "[t]hreadbare recitals of the elements of a cause of action, supported by mere conclusory statements," or if "the well–pleaded facts do not permit the court to infer more than the mere possibility of misconduct." *Iqbal*, 129 S. Ct. at 1949–50.

III. Discussion

Defendants argue that Plaintiff's action is time–barred by the three–year limitations period set out in the Plan policy. In her Opposition, Ms. Heimeshoff argues that her action is not time–barred because the Plan policy is ambiguous with respect to when proof of loss is actually due, because Hartford did not provide notice of the three–year limitations period in its denial of her claim, and because the Plan SPD was misleading.

ERISA does not prescribe a limitations period for actions under 29 U.S.C. § 1132, "[t]herefore the applicable limitations period is that specific in the most nearly analogous state limitations statute." *Burke v. PriceWaterHouseCoopers LLP Long Term Disability Plan*, 572 F.3d 76, 78 (2d Cir. 2009). Under Connecticut law, insurance carriers may contract for a limitations period in which a claim may be filed, as long as that period is not less than one year. *Voris v. Middlesex Mut. Assurance Co.*, 297 Conn. 589, 596 (2010); *see also* Conn. Gen. Stat. § 38a-290. A limitations period that begins to run before a claimant may bring legal action is enforceable. *Burke*, 572 F.3d at 79–81 (upholding three–year limitations period in insurance contract that prohibited claimant from bringing legal action "more than three years after the time written Proof of Loss is required to be furnished").

The Plan policy here states that "[l]egal action cannot be taken against The Hartford . . . 3 years after the time written proof of loss is required to be furnished according to the terms of the policy." (Policy at 000029.) The policy also states that proof of loss "must be sent to The Hartford within 90 days

after the start of the period for which The Hartford owes payment." (*Id.* at 000027.) Ms. Heimeshoff argues that this provision is ambiguous because it continues: "If proof is not given by the time it is due, it will not affect the claim if: (1) it was not possible to give proof within the required time; and (2) proof is given as soon as possible; but (3) not later than 1 year after it is due, unless you are not legally competent." (*Id.*) In her Complaint, Ms. Heimeshoff claims that she was unable to perform the essential duties of her occupation as of June 6, 2005 (Compl. ¶ 19), is entitled to long–term disability benefits from June 7, 2005 (*id.* ¶ 81), and had to stop working on June 8, 2005 (*id.* ¶ 15). Therefore, according to the Complaint, at the latest, the period for which Hartford would have owed payment began on June 8, 2005, and written proof of loss would have been due on September 6, 2005 at the latest.

Ms. Heimeshoff's counsel contended at oral argument, however, that this could not have been the due date for written proof of loss, because Hartford requested, and Ms. Heimeshoff provided, additional information regarding her medical condition and loss throughout the claim and appeal process. The administrative record reflects that in preparing her appeal, Ms. Heimehoff's counsel requested by letter dated May 24, 2007 that Hartford "provide until September 30, 2007 to submit additional materials." (Admin. R., Ex. B to Begos Decl. at 000095.) The Appeal Unit at Hartford responded on June 5, 2007: "[W]e will grant an extension ending on September 30, 2007. If we do not receive additional information by that time, we will evaluate your appeal using the information

currently in your file." (*id.* at 000096.) Even if, as Ms. Heimeshoff argues, the Plan policy is ambiguous given her additional submissions throughout the claim and appeal process, pursuant to the June 5 letter from Hartford, written proof of loss was due, at the latest, on September 30, 2007.

The Plan unambiguously disallows legal action more than three years after the time written proof of loss is required to be furnished. (*See* Policy at 000029.) Therefore, even crediting Ms. Heimeshoff's argument regarding the uncertainty of written loss due dates, she could not take legal action any later than September 30, 2010. She filed her Complaint on November 18, 2010, and it is therefore untimely under the terms of the Plan policy.

Ms. Heimeshoff nevertheless argues that this case is not time-barred because Hartford did not include in its denial letter notice of the limitations period as required by ERISA. Ms. Heimeshoff relies entirely on the Southern District of New York's decision in *Novick v. Metropolitan Life Insurance Co.*, 764 F. Supp. 2d 653 (2011), which she claims stands for the proposition that "an initial adverse determination letter must state the limitations period for judicial review imposed by an SPD." (Opp'n at 22.)

In *Novick*, after initially approving plaintiff Karen Novick's short-term disability benefits due to her lyme disease symptoms, defendant Metropolitan Life Insurance Company terminated those benefits and denied her long-term benefits claim in a letter

that informed her that she could appeal the termination internally, and if her appeal were denied, she could bring a civil action. 764 F. Supp. 2d at 656–57. "The letter did not mention any limitations period for bringing that action." *Id.* at 657. Metropolitan later denied her appeal in a letter, which "[l]ike the initial termination letter, . . . did not mention any time limits applicable to any civil action." *Id.* at 658. The court found that in failing to state the limitations period applicable to any civil action in the initial termination letter, Metropolitan violated the Department of Labor's regulations governing ERISA, and therefore the six-year limitations period under New York law, rather than the limitations period in the SPD, which was 6 months following the issuance of the final written decision on appeal, applied to Plaintiff's action. *Id.* at 664. It interpreted the DOL's regulation governing ERISA claim procedures at 29 C.F.R. § 2560.503–1(g)(1)(iv)—which requires that notification of adverse benefit determination contain "[a] description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review"—to include within the "review procedures" for which time limits must be described any civil action initiated after the appeal. *Id.* at 660–662.

Novick's outcome notwithstanding, 29 C.F.R. § 2560.503–1(g)(1)(iv) unambiguously requires that the notification of benefit determination include "a statement of the claimant's *right* to bring a civil action," whereas its description of the necessary

notification for claim review procedures requires "[a] description of the plan's review procedures and the time limits applicable to such procedures." That the regulation requires notification of time limits for plan review procedures but says nothing about time limits with respect to civil actions suggests that the DOL did not intend to require such a time limit notification in the benefit determination. The court in *Novick* found that because the limitations period for seeking judicial review "is established by the plan itself, and not by law, judicial review must be a part of and governed by *the plan's* review procedures," 764 F. Supp. 2d at 661 (emphasis in original); however, while the time period for commencing a civil action is established by the plan, the judicial review process itself is not subject to the plan. A civil action seeking remedies under the plan is a separate and distinct review process from those contemplated in the claim proceedings under a benefits plan.

The court in *Novick* also relies on *Chappel v. Laboratory Corp. of America*, 232 F.3d 19, 726–27 (9th Cir. 2000), in which the Ninth Circuit held that post–denial arbitration of ERISA claims was a part of the claims procedure, and that therefore benefits denials letters would have to include time limits applicable to the arbitration. Arbitration is a different review process than a civil action in a district court, however, and particularly given the requirement in the DOL regulation that states only a statement of the claimant's right to a civil action must be included in the denial letter, it is unclear how this bears on the limitations period for a civil action. The Court therefore declines to follow *Novick*. Hartford was not required to inform Ms. Heimeshoff

of the Plan's limitations period for legal action in its benefits determination letter, thus its failure to do so does not affect the untimeliness of Ms. Heimeshoff's Complaint.

IV. Conclusion

For the reasons stated above, Defendants' motion [Doc. # 29] to dismiss is GRANTED. The Clerk is directed to close this case.

IT IS SO ORDERED.

/s/ Janet Bond Arterton, U.S.D.J.

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

JULIE HEIMESHOFF,

Plaintiff-Appellant,

v.

HARTFORD LIFE & ACCIDENT
INSURANCE CO. AND WALMART STORES,

Defendants-Appellees.

No. 12-651-cv

VERBATIM REPORT OF PROCEEDINGS

BEFORE THE HONORABLES
BARRINGTON D. PARKER;
RICHARD C. WESLEY; JOHN GLEESON

SEPTEMBER 10, 2012

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(Beginning of transcription at 10:28 a.m.)

THE COURT 1: The next case is Heimeshoff vs. Hartford Life. Wait until the clear, Counsel. Just have a seat for a second. I like to let the lawyers walk out, Mr. Krafchick, so that the noise behind you subsides. Take your time, Mr. Tovaro.

Okay. Mr. Krafchick. This is long distance day, I think, Mr. Krafchick.

MR. KRAFCHICK: I guess so. My eight minutes in the sun.

THE COURT 1: Well, I'll probably be gracious with you. Go ahead.

MR. KRAFCHICK: Thank you. I'd like to start with Met Life versus Glenn, which says that in ERISA cases you have higher than marketplace standards and the fiduciary acts for the exclusive purposes of the beneficiary or the participants.

THE COURT 2: Let me ask you this. If Burke versus PriceWaterHouse was correctly decided, can you prevail?

MR. KRAFCHICK: My feeling is is that Worth versus -- that case does not deal with the regulations in the same way that I think ERISA intends it and the Supreme Court intended it.

THE COURT 2: I don't get the answer to the question. What's the answer to the question, Mr. Krafchick?

MR. KRAFCHICK: I apologize, Your Honor. I'm not familiar with that particular case.

THE COURT 1: You're familiar with Burke.

MR. KRAFCHICK: Oh, Burke. I thought you said Worth. No, Burke.

THE COURT 1: No. Burke, Burke.

MR. KRAFCHICK: No, Burke I do not –

THE COURT 1: Judge Hartford and I were both on the Burke decision for a carry-on decision

along with Judge Murtha. Got a new sidekick Lisa in here.

MR. KRAFCHICK: Lucky me.

THE COURT 1: Some suggest it was wrongly decided.

MR. KRAFCHICK: I guess it takes chutzpah a little bit.

THE COURT 1: Either that or –

MR. KRAFCHICK: But I believe, Your Honor, that if Burke is correctly decid· d, it still fails, because the notices under ERISA were not given, and I think that Judge Hollowell in Novick did a great job in talking about the importance of the notice, and the US Supreme Court says the notice of the time limits is part of the minimum regulations that apply in this case, and they have to be provided in a manner understood by the claimant. Now, if –

THE COURT 2: First of all, you spend some ink in your brief encouraging us to overrule Burke, and I can't speak for Judge Wesley. I read those pages with great interest.

But in any event, what is your theory under which your submission was timely?

MR. KRAFCHICK: The theory is is that it is not that the submission was timely, it is the failure of the defendants to provide notice of the accrual date and the time left in their denial letters and

their summary plan description, and the ERISA regulations, we believe, requires that.

So let's say they're right and Burke is right and that we had one year left at the time of the –

THE COURT 2: What was it you didn't know? If you looked at -- I mean, you were told what the limitations periods were. You knew that.

MR. KRAFCHICK: We were told that it was three years from the last date proof of loss was requested. If you look at the plan particularly, you will see in the plan that Hartford had the ability to request proof of loss up until the time of final denial.

It doesn't say -- and they're trying to run it from the initial, the initial denial of this claim. And our point is is if they're running it from the initial denial, they can do that, that's not clear from the plan when the accrual date would be. It's a moving date.

THE COURT 2: But you were aware of what the time limitations were.

MR. KRAFCHICK: No. I was aware of what the plan said, and I did not believe that – you have in this circuit as well as in other circuits the time from which the statute runs with similar language, is three -- is the final denial.

THE COURT 1: But that's where the plan uses the word term. But in Burke we said quite clearly that we didn't have to decide that accrual dispute

that incurs within this circuit itself, because the plan itself was crystal clear. We use the term plain language, that the statute of limitations began to run from the time of proof of loss.

And you yourself in your oral argument in front of the court around 216 or 213 acknowledge that it was proof of -- they approved proof of loss. And even if you go to the latest proof of loss, September 30, 2007, which was the time that you'd asked for additional time to support the administrative appeal, your actions are still untimely.

MR. KRAFCHICK: I understand that, Your Honor. The fact is, though, that Aetna had the ability to require proof of loss up until the time they had the final denial.

THE COURT 1: Well, let me ask you.

MR. KRAFCHICK: And -- go ahead.

THE COURT 1: No. Go ahead. Finish.

MR. KRAFCHICK: That is my point. And the plan is not clear when proof of loss is finally done.

THE COURT 1: Is it your position that even if you had -- you had the -- Aetna had sent you the plan documents in 2006, had they not?

MR. KRAFCHICK: Correct.

THE COURT 1: And you've not -- you've been very straightforward about that.

MR. KRAFCHICK: Correct.

THE COURT 1: And I appreciate that. Is it your view that even though you had the plan documents, a difficulty with what you see as noncompliance with the regulations would forgive the or would not excuse the inadequacy of that notice?

MR. KRAFCHICK: If I understand your question –

THE COURT 1: If you understood what the timelines were and even though the notice were inadequate, would you still be held to the earlier time lines and do you think that excuses your noncompliance, if we thought it were noncompliance with the timelines?

MR. KRAFCHICK: To put it another way, if they had said you have until September 30th and, by the way, that, that's when your three years starts running, which I think is what ERISA requires, then we would have no case.

THE COURT 1: So you tie yourself to the mast of Novick then, right?

MR. KRAFCHICK: The notice requirements?

THE COURT 1: Yes.

MR. KRAFCHICK: Yes.

THE COURT 1: Now, Novick, Novick of course creates an interesting requirement, because you and I would both agree that the part of the regulations which deals with the final notice does not have a timeline requirement.

MR. KRAFCHICK: Correct. But you look –

THE COURT 1: That would mean that you have to get notice at the time of the initial determination of the time period, but you don't have to get notice of the time period when you've got the final determination from which then you have a cause of action in District Court? Or bring a claim in this court, rather?

MR. KRAFCHICK: There are two places the notice should be. One in the summary plan description and one in the denial letters or even the first letter of the denial, and they failed, as they did in Novick, to provide it anywhere, at all.

THE COURT 1: Why do you think the regulation's written the way it is as to the initial determination that subparagraph 4 of G. You know, I'm not going to go through the whole litany, but –

MR. KRAFCHICK: Got it.

THE COURT 1: -- we know what we're talking about when we talk about G.

MR. KRAFCHICK: Got it.

THE COURT 1: So the description of the plan's review procedures and time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under 502 of the act, right?

MR. KRAFCHICK: Right.

THE COURT 1: Why did they put the word statement in there? Why didn't they just say a description of the -- if indeed the right to bring a claim in District Court was part of the plan, even though it's statutorily imposed and governed by rules totally separate and apart from the plan, why didn't they just say a description of the plan's review procedures and time limits applicable to such procedures including the claimant's right to bring a civil action?

Why did they bring a statement? Why did they insert a statement of in there? Why do you think they did that?

MR. KRAFCHICK: I can't explain that, Your Honor, because I'm not the Department of Labor. But as we read it, when you have to –

THE COURT 1: That presumes there's logic how is it that the Department Of labor, but we'll go there another day.

But why do you think then in the final notice they don't include the timing provisions for the bringing of the cause of action?

MR. KRAFCHICK: Let's assume you're correct in that. They had to bring it in the notice that preceded that and they didn't do it there, so there's their violation of ERISA.

THE COURT 1: Would you agree with me that their final notice complied with sub J?

MR. KRAFCHICK: No, because I agree with the analysis in Novick and that sub J –

THE COURT 1: Novick said nothing about J. It dealt with G.

MR. KRAFCHICK: Right.

THE COURT 1: So Judge Hollowell didn't deal with the final notice. He kind of left that out.

MR. KRAFCHICK: That he did.

THE COURT 1: So I mean, it does create a bizarre result. It says what your rights are to bring an action after initial determination including the time limits, but when you're close to God trying to bring a lawsuit, it doesn't tell you the time.

MR. KRAFCHICK: You're looking at letters that were written December 8th of '05, May 31st of '06, May 24th of '07, Sep –

THE COURT 1: Oh, I know all about the letters.

MR. KRAFCHICK: Yeah.

THE COURT 1: But I'm talking about the law now.

MR. KRAFCHICK: Yeah. The law says they have to have it in a summary plan description. They didn't. The law says they have to have it in at least the earlier denial letter. They didn't.

THE COURT 1: Let me ask you a couple more questions. And I know Judge Gleeson may have a question for you.

MR. KRAFCHICK: Yeah.

THE COURT 1: The District Court in Novick tied its start to Chappel also, did it not?

MR. KRAFCHICK: Correct. I'm familiar with that case.

THE COURT 1: But in Chappel, the issue in Chappel was there was an inserted arbitration proceeding into the plan, a mandatory arbitration proceeding, following the denial of benefits. Is that correct?

MR. KRAFCHICK: Correct.

THE COURT 1: And the problem with that was, as the circuit saw in the 9th Circuit in Chappel was is that at that point in time it was unclear as to whether a plan administrator could offer mandatory

arbitration in lieu of or in satisfaction of the claim -- the right to bring a claim in Federal Court, right?

MR. KRAFCHICK: Right.

THE COURT 1: And so what the court did was it acknowledged that it wasn't going to decide the issue of whether it would be substituted. Later on the department inserted regulations that deal with arbitration, but they didn't exist at that time.

So it decided that it was going to leave out the issue of whether it's one or the other. Didn't it say that?

MR. KRAFCHICK: I believe at that time. But also look at –

THE COURT 1: Then it said a curious thing. It said there were no provisions with regard to arbitration in the existing regulations in term of timing or notice or anything else like that, didn't it?

MR. KRAFCHICK: Right.

THE COURT 1: So then it presumed that the arbitration, the arbitration which was required by the plan, not by the statute, had to fall within the notice and time provisions of sub G. Isn't that what it said?

MR. KRAFCHICK: Right. But –

THE COURT 1: Then how is it that the District Court in Novick somehow extrapolated that to

equate a judicial proceeding imposed by statute and governed by rules totally separate and apart from the rules of how the plan administers the claim, somehow becomes a part of the proceeding, of the internal plan itself?

MR. KRAFCHICK: Well, if you look at the subsequent case of Soli[phonetic] in the 9th Circuit, it made clear –

THE COURT 1: In Schoff?

MR. KRAFCHICK: Pardon? Yeah.

THE COURT 1: I'm glad you bring that up. In Schoff the plaintiff conceded that the initial notice provision did not need to notify the timing with regard to the right to bring a cause of action in Federal Court. It conceded that.

The issue was the plaintiff argued that California law inserted a separate obligation with regard to the notice and the district courts and the court said no, it does not, and the circuit agreed.

So I don't know how Schoff or Chappel even remotely decide the issue that the District Court decided to embrace and use as its linchpin in Novick.

MR. KRAFCHICK: In this case, if you look at the regulations and the obligations they have in their minimum regulations and you look at what the obligations are and you look at the higher than marketplace duties that are placed on Hartford, it's

very difficult to say that they acted in the sole interests of the participants or beneficiaries.

THE COURT 1: Lastly, have you thought about the implications of this for a policy that span states, this interpretation?

MR. KRAFCHICK: You mean the argument that 50 million states will have to make decision -- 50 states –

THE COURT 1: Well, just take bordering states, Connecticut and New York.

MR. KRAFCHICK: Okay.

THE COURT 1: Connecticut says –

MR. KRAFCHICK: All –

THE COURT 1: Wait. Let me finish. So the plan document covers Walmart employees. There's a great Walmart store in Geneseo. We love having it there. The merchants on Main Street aren't too happy, but we like having it there. Pay low prices, okay? This is a Walmart store in Connecticut. In New York you can set the statute of limitations down to a month or two months. Federal law might kick in as to whether it's unreasonable or not, but you can shorten it down to next to nothing.

In Connecticut it has to be a minimum of one year, does it not?

MR. KRAFCHICK: Right.

THE COURT 1: So will there be in that in that provision, if that regulation requires it, will there be an asterisk in a list of all the various states?

MR. KRAFCHICK: There are two things that they had to do. One is tell us the accrual date, which they didn't, and second, is tell us the time, a reasonable time.

THE COURT 1: Where in the regulations does it require you to tell the accrual date?

MR. KRAFCHICK: The time limits. How do you figure a time limit without a stop point?

THE COURT 1: Burke precludes you on that argument. Unless you can get six active – or seven active members of this court to call for en banc, we ourselves don't have the authority.

MR. KRAFCHICK: I'm not saying. Let's say Burke is still good law.

THE COURT 1: Burke is good law. You're stuck with that.

MR. KRAFCHICK: Right. I understand that. So then in the notice under G, they should have told us at that time your statute has been running and you have one year left or six months left or a year and a half left.

THE COURT 1: Judge Gleeson, did you have anything else?

THE COURT 3: I did. Thank you.

THE COURT 1: Go ahead. Sorry.

THE COURT 3: I thought you were going to make a textual argument under this reg. The language that Judge Wesley quoted to you earlier says, a description of the plan's review procedures. This is sub 4. A description of the plan's review procedures and the time limits applicable to such procedures.

MR. KRAFCHICK: Correct. That's in B.

THE COURT 3: Okay. And as to those procedures, the time limits need to be alluded to in the denial, correct?

MR. KRAFCHICK: That is our position, Your Honor.

THE COURT 3: And then it doesn't say -- then there's a comma, and it doesn't say and a statement of the claimant's right to bring a civil action, which would separate that out. Rather, it says including a statement, and the word including suggests to me textually that the right to bring a civil action is one of the procedures on the earlier side of the comma.

Do you understand what I'm saying?

MR. KRAFCHICK: Yes. That's in B(2), Your Honor, and I understand exactly what you're saying, and that is part of our argument. I guess in the eight minutes I lost sight of it, but that to me is an important part of it because it sets out under B the obligation to establish a reasonable claims

procedure, and then says the applicable time – all claims procedure must include the applicable time frames included as part of a summary plan description in two and the claims procedures comply with requirements and then it goes forward on that.

And then it finally says the claims procedures do not contain any provision and are not administered in any way that unduly inhibits, hampers the initiation or processing of claims for benefits.

THE COURT 1: Wait a second. The plain language says a description of the plan's review procedures and time limits. If the right to bring an action is not part of the plan review, then you can't extrapolate -- you can't extrapolate the right to bring an action to include including within that the time periods in which to bring an action, can you?

MR. KRAFCHICK: In MetLife versus Glenn the Supreme Court said at the end of the quote, supplements, marketplace and regulatory controls with judicial review of individual claims denials, according to 1132A1B, and the A thing.

So I think the Supreme Court sees the review procedures as part of the claims procedures.

THE COURT 1: All right. Fair enough. Thank you. You had 19 minutes.

MR. KRAFCHICK: Pardon?

THE COURT 1: You ended up with 19 minutes, Mr. Krafchick. That's because you're from Seattle.

MR. KRAFCHICK: Will I get my...
THE COURT 1: Yes, you do, of course.

MR. KRAFCHICK: Thank you.

MR. BEGOS: Good morning, Your Honors. Burke, as the court has mentioned, is good law, it's binding on this case, it's on all fours. It held that the exact policy provision that's at issue in this case was clear and unambiguous and enforceable by its terms.

The second part of the case is the actual notice of the limitation provision in the policy. Under Veltri and under well-established law of equitable tolling, the plaintiff's actual knowledge of the provision, the limitation provision, prevents an equitable tolling argument, even if a regulation required some greater disclosure that didn't happen. There's no dispute here that –

THE COURT 1: We don't -- are you saying we don't need to reach the Novick issue; that we could simply be given the concession that plaintiff's counsel had the plan from 2006 and our conclusion in Burke that the language is clear in Burke as to when it starts to run. That notwithstanding whether you did or did not have to give that notice, he's not entitled to use the absence of that notice for some kind of tolling provision?

MR. BEGOS: That's correct, Your Honor. Under Veltri it clearly held -- Veltri dealt with a

failure to apprise the claimant of his right to bring a civil action. It didn't relate to time periods.

But the court stated that it was not holding that any failure to comply with the regulation would justify equitable tolling and, for example, the claimant's actual knowledge of the right to bring a civil action would preclude equitable tolling. So the court could in this case determine that the plaintiff and her attorney's actual knowledge of the time limit makes it unnecessary to reach the regulation.

THE COURT 1: The flaw in Veltri was it didn't tell about the right to appeal, so there was noncompliance with actually the same section itself.

MR. BEGOS: Yeah. I think it was the right to bring a civil action, but you might be right about the right to administratively appeal. But it was the same subsection of the regulation.

I do think the question of the regulation is a very interesting one, you know, but in all candor, I don't believe the court has to reach it. I think the court certainly could and would be probably, as far as I can tell, the first circuit to squarely address this issue of whether the regulations require disclosure regarding post-administration litigation time limits and procedures. And my view is that under various ways of looking at the regulation, it clearly doesn't.

When you look at the regulations as a whole, which are probably as long as one of those Percy Jackson books, but not nearly as interesting –

THE COURT 1: Well, they aren't that long.

MR. BEGOS: -- they talk almost entirely about the plan's review proceedings, and they have very limited mentions of things that might occur after the plan. And the limited mentions are generally the language that was quoted on the prior argument here, that there has to be a statement of the right to bring a civil action. And that's basically it.

The Chappel case held that the regulations related to the plan's internal proceedings. And as Your Honor mentioned, there was this strange situation where there's a question whether arbitration was an internal proceeding or a litigation proceeding. So the regulations don't deal with what happens after the administrator closes the administrative record and the case goes to court.

Secondly, as Your Honors noted, the structure of the language. That it requires a description of the plan's review proceedings and the time limits for it, and the statement of –

THE COURT 3: No, no, no. That's not what it says.

MR. BEGOS: I'm paraphrasing, Your Honors.

THE COURT: It says including a statement, and that's my concern textually.

MR. BEGOS: Including a statement, Your Honor, and I think that what's important there is that I understand the including, but including a

statement of. And so it specifically says what has to be included.

THE COURT 3: But the word including lends itself, lends to the inference or supports the inference that the statement of the claimant's right to bring a civil action is among the procedures referenced in the first part of the sentence. You get my concern?

MR. BEGOS: I do, Your Honor.

THE COURT 3: And I have another concern. And I hear your argument about this is a counseled plaintiff, but my concerns extend beyond to this particular case. Even reading the proof of loss term as broadly as counsel wants, your adversary wants us to read it, he's got a problem. I get that.

I don't understand why, just as a matter of fairness, these denial letters don't, at the very least -- I read your argument in front of Judge (unintelligible) and nobody suggests you have to canvas of law of 50 states.

As a matter of fairness, why, at the very least, the claimant isn't told what I think a lay person would need to be told, which is it's a three year limit and it does not run from this denial. In fact, it's probably been running for a while already. Words to that effect. I don't get that, just as a matter of fairness.

MR. BEGOS: I think -- I have two answers to that. One is, depending on where an action is

brought, that might be an inaccurate statement of the claimant's rights.

So for example, if the claimant sues in the Fourth Circuit, a statement that says they have three years from the date proof of loss is due would not be accurate, because the time limit would be more than likely three years from the date of the final claim determination.

THE COURT 3: Well, to that extent, it would be erroneous, but utterly harmless to the beneficiary.

THE COURT 1: No re -- I'm sorry. Go ahead.

MR. BEGOS: I think you're –

THE COURT 3: So what you're saying is there might be some instances, not here, where the three years will run from the denial. Okay. Fair enough. Nobody's going to worry about those folks.

The point is, in a lot of places, right, in a lot of places, it begins running a lot earlier, like here, two years earlier, and don't you think as a matter of fairness the policy holder ought to know that, a noncounseled policy holder?

MR. BEGOS: I take your point, Your Honor, and what I would say is that a claim administrator certainly could make that type of disclosure on a voluntary basis, but it's not required by the regulations, and I think the –

THE COURT 3: Unless the text of this regulation reads -- is read to mean what it says.

MR. BEGOS: Yes. But the additional problem with reading the regulation -- or there's two additional problems with reading the regulation as requiring that disclosure.

Number one, as Judge Wesley identified, subsection J of the regulation, which deals with the letters announcing the adverse determination on review, doesn't say anything about time limits, and it is anomalous to suggest that the initial determination letter, which doesn't give the claimant the right to sue, would require disclosure of the right to sue time limit, but not the –

THE COURT 1: If this were part of the plan review problem, why have any of that language after the including? Why have any of that? If this is part of the plan review, if that's what the Department of Labor intended, the right to bring an action under 502 is extraneous. You'd just say including all the procedures under the plan for review of this, which would include the statutory mandate. But I don't understand why you even need that.

MR. BEGOS: Well, I –

THE COURT 1: Clearly, clearly, the fact that they say and include this for some reason seems to identify that as separate from the plan itself; otherwise, there would be no reason to mention it.

MR. BEGOS: It appears, Your Honor, that the Department of Labor was concerned about claimants knowing that they had a right to go to court. So another part of the regulations contains a required statement of rights under ERISA. And if you read -- and the regulations quote verbatim what has to be in plan disclosure documents, and that specifically says with respect to litigation you have a right to bring an action after your claim is fully administered.

I'm paraphrasing there, but it's, again, you have the right to bring an action. So that seems to be almost talismanic language that the Department of Labor uses that there's a right to bring a civil action.

If I can make one other point to respond to Judge Gleeson. The other issues with respect to interpreting the regulations to include the litigation as a plan procedure is the problem of where -- where does one stop? I don't think one can textually interpret the regulation as saying you have to disclose the time limit for litigation, but none of the other procedures relating to litigation.

So I think if litigation is a plan, a plan review procedure, then it would require administrators to describe litigation as a plan review procedure, and I'm not sure where that stops. Is it filing a complaint, is it serving a complaint, is it summary judgment practice, is it discovery, is it jury trial or no jury trial, is it appeal?

And I think that if one were to interpret it that way, it causes more problems than it might solve.

THE COURT 1: Fair enough.

MR. BEGOS: Thank you.

THE COURT 1: Thank you.

Mr. Krafchick, you have two minutes.

MR. KRAFCHICK: If defendant, Mr. Bego's, conceded that the administrator could provide that notice, then why didn't they? To me it's a substantial fairness obligation.

THE COURT 1: It's a question of what the regulations mean. It's not a question of us deciding whether we would prefer something different. It's a question what the regulations require.

But my bigger problem, ultimately, is with Veltri and your situation of having had this since '06, and Burke says that the language is not ambiguous. I mean, I don't know how you get out of that Burke box.

Because Veltri -- in Veltri, the notice was inadequate under the very regulation that you claim is the premise for your tolling.

MR. KRAFCHICK: The problem, the problem with that is when does the statute start running? If they –

THE COURT 1: We told you in Burke when it starts running, and that's the law of this circuit. You're stuck with that.

MR. KRAFCHICK: Well, I understand that, Your Honor.

THE COURT 1: So if the law in the circuit is clear, and the law in the circuit is clear that this very provision is not ambiguous and the law in the circuit under Veltri is clear that an inadequate notice with regard to the claims proceedings under the very section, subsection that you claim, is not subject to equitable tolling, if you have the actual provisions in your hand, how, how are you going to get out from underneath Veltri and Burke?

MR. KRAFCHICK: I would turn it around, Your Honor, if I believed looking at the law and my understanding of the law and even Burke that the statute would start running at the time of the final decision because the plan permitted the company to ask for more information up until the time of the final denial.

THE COURT 1: That's not what Burke says.

MR. KRAFCHICK: I understand that.

THE COURT 1: Okay.

MR. KRAFCHICK: And I do believe Burke, with all due respect to both Honors, is decided incorrectly.

THE COURT 1: Look, you're more than welcome to your opinion, and believe me, that's okay, but the problem is is that notwithstanding whether we ourselves think it's wrong right now, we don't

have the authority to overturn it. Only seven votes for a en banc, if you invoke a decision by seven active judges of this court, is capable of doing that.

MR. KRAFCHICK: I'm quite aware of that, Your Honor.

THE COURT 1: Well, you get your chance.

MR. KRAFCHICK: Yeah. There are other places to go to, Your Honor.

THE COURT 1: Thank you. Have a safe trip home. Well argued. Nicely briefed. Thank you very much. Very interesting issue. United States -- you'll hear from us in due course. The matter's being submitted.

(End of transcription at 10:57 a.m.)

TRANSCRIPTION CERTIFICATE

I , CHERYL J . HAMMER, the undersigned Certified Court Reporter in and for the state of Washington , do hereby certify :

That the foregoing transcript was transcribed under my direction ; that the transcript is true and accurate to the best of my knowledge and ability to hear the audio ; that I am not a relative or employee of any attorney or counsel employed by the parties hereto; nor am I financially interested in the event of the cause.

WITNESS MY HAND this 6th day of November 2012.

CHERYL J. HAMMER
Certified Court Reporter, CCR No. 2512

STATUTES AND REGULATIONS INVOLVED

Title 29, United States Code, Section 1001(a):

(a) The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations; that they have become an important factor in commerce because of the interstate character of their activities, and of the activities of their participants, and the employers, employee organizations, and other entities by which they are established or maintained; that a large volume of the activities of such plans are carried on by means of the mails and instrumentalities of interstate commerce; that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans; that they substantially affect the revenues of the United States because they are afforded preferential Federal tax treatment; that despite the enormous growth in such plans many employees with long

years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans; that owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered; that owing to the termination of plans before requisite funds have been accumulated, employees and their beneficiaries have been deprived of anticipated benefits; and that it is therefore desirable in the interests of employees and their beneficiaries, for the protection of the revenue of the United States, and to provide for the free flow of commerce, that minimum standards be provided assuring the equitable character of such plans and their financial soundness.

Title 29, United States Code, Section 1001(b):

(b) It is hereby declared to be the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

Title 29, United States Code, Section 1022(a):

(a) A summary plan description of any employee benefit plan shall be furnished to participants and beneficiaries as provided in section

1024(b) of this title. The summary plan description shall include the information described in subsection (b) of this section, shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan. A summary of any material modification in the terms of the plan and any change in the information required under subsection (b) of this section shall be written in a manner calculated to be understood by the average plan participant and shall be furnished in accordance with section 1024(b)(1) of this title.

Title 29, United States Code, Section 1022(b):

(b) The summary plan description shall contain the following information: The name and type of administration of the plan; ... the name and address of the person designated as agent for the service of legal process, if such person is not the administrator; ... the plan's requirements respecting eligibility for participation and benefits; ... circumstances which may result in disqualification, ineligibility, or denial or loss of benefits; the source of financing of the plan and the identity of any organization through which benefits are provided; the date of the end of the plan year and whether the records of the plan are kept on a calendar, policy, or fiscal year basis; the procedures to be followed in presenting claims for benefits under the plan including the office at the Department of Labor through which participants and beneficiaries may seek assistance or information regarding their rights

under this chapter and ... the remedies available under the plan for the redress of claims which are denied in whole or in part (including procedures required under section 1133 of this title), ...

Title 29, United States Code, Section 1104(a)(1):

(a)(1) Subject to sections 403(c) and (d), 4042, and 4044 [29 USCS §§ 1103(c), (d), 1342, 1344], a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and—

(A) for the exclusive purpose of:

(i) providing benefits to participants and their beneficiaries; and

***

(D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this title and title IV.

Title 29, United States Code, Section 1133(1) – (2):

In accordance with regulations of the Secretary, every employee benefit plan shall—

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied

for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

Title 29, Code of Federal Regulations, Section 2520.102-2(b)

(b) General format. The format of the summary plan description must not have the effect to misleading, misinforming or failing to inform participants and beneficiaries. Any description of exception, limitations, reductions, and other restrictions of plan benefits shall not be minimized, rendered obscure or otherwise made to appear unimportant. Such exceptions, limitations, reductions, or restrictions of plan benefits shall be described or summarized in a manner not less prominent than the style, captions, printing type, and prominence used to describe or summarize plan benefits. The advantages and disadvantages of the plan shall be presented without either exaggerating the benefits or minimizing the limitations. The description or summary of restrictive plan provisions need not be disclosed in the summary plan description in close conjunction with the description or summary of benefits, provided that adjacent to the benefit description the page on which the restrictions are described is noted.

Title 29, Code of Federal Regulations, Section 2520.102-3(s):

Contents of summary plan description.

(s) ...**The summary plan description *must* accurately reflect the contents of the plans** ...

The following information ***shall be included*** in the summary plan description of both employee welfare benefit plans and employee pension benefit plans, except as stated otherwise in paragraphs (j) through (n):

The procedures governing claims for benefits (including ... procedures for filing claim forms, providing notifications of benefit determinations, and reviewing denied claims in the case of any plan), applicable time limits, and remedies available under the plan for the redress of claims which are denied in whole or in part (including procedures required under section 503 of Title I of the Act). ...

Title 29, Code of Federal Regulations, Section 2560.503-1(a):

(a) Scope and purpose. In accordance with the authority of sections 503 and 505 of the Employee Retirement Income Security Act of 1974 (ERISA or the Act), 29 U.S.C. 1133, 1135, this section sets forth minimum requirements for employee benefit plan procedures pertaining to claims for benefits by participants and beneficiaries (hereinafter referred to as claimants). Except as otherwise specifically provided in this section, these requirements apply to every employee benefit plan described in section 4(a) and not exempted under section 4(b) of the Act.

Title 29, Code of Federal Regulations, Section 2560.503-1(b)(1-3):

(b) Obligation to establish and maintain reasonable claims procedures. Every employee benefit plan shall establish and maintain reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations (hereinafter collectively referred to as claims procedures). The claims procedures for a plan will be deemed to be reasonable only if –

(1) The claims procedures comply with the requirements of paragraphs (c), (d), (e), (f), (g), (h), (i), and (j) of this section, as appropriate, except to the extent that the claims procedures are deemed to comply with some or all of such provisions pursuant to paragraph (b)(6) of this section;

(2) A description of all claims procedures (including, in the case of a group health plan within the meaning of paragraph (m)(6) of this section, any procedures for obtaining prior approval as a prerequisite for obtaining a benefit, such as preauthorization procedures or utilization review procedures) and the applicable time frames is included as part of a summary plan description meeting the requirements of 29 CFR 2520.102-3;

(3) The claims procedures do not contain any provision, and are not administered in a way, that unduly inhibits or hampers the initiation or processing of claims for benefits. ...

Title 29, Code of Federal Regulations, Section 2560.503-1(g)(1)(iv):

(g) Manner and content of notification of benefit determination. (1) Except as provided in paragraph (g)(2) of this section, the plan administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv). The notification shall set forth, in a manner calculated to be understood by the claimant --

(iv) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review;

Title 29, Code of Federal Regulations, Section 2560.503-1(j)(4):

(j) Manner and content of notification of benefit determination on review. The plan administrator shall provide a claimant with written or electronic notification of a plan's benefit determination on review. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv). In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the claimant –

* * *

(4) A statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain the information about such procedures described in paragraph (c)(3)(iv) of this section, and a statement of the claimant's right to bring an action under section 502(a) of the Act;

EXCERPTS FROM HARTFORD INSURANCE POLICY FOR WAL-MART STORES, INC. (Second Circuit JA 49 and 51)

CLAIMS

...

Proof of Loss

Written proof of loss must be sent to The Hartford within 90 days after the start of the period for which The Hartford owes payment. After that, The Hartford may require further written proof that you are still Disabled. If proof is not given by the Time it is due, it will not affect the claim if:

(1) it was not possible to give proof within the required time; and

(2) proof is given as soon as possible; but

(3) not later than 1 year after it is due, unless you are not legally competent.

...

The Hartford reserves the right to determine if proof of loss is satisfactory.

...

Legal Actions

Legal action cannot be taken against The Hartford:

(1) sooner than 60 days after due proof of loss has been furnished; or

(2) **after the shortest period allowed by the laws of the state where the policy is delivered.** This is 3 years after the time written proof of loss is required to be furnished according to the terms of the policy.

WAL-MART STORES SUMMARY PLAN DESCRIPTION (Second Circuit JA 157-162)

ERISA INFORMATION

THE FOLLOWING NOTICE CONTAINS IMPORTANT INFORMATION

This employee welfare benefit plan (Plan) is subject to certain requirements of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA requires that you receive a Statement of ERISA Rights, a description of Claim Procedures, and other specific information about the Plan. This document serves to meet ERISA requirements and provides important information about the Plan.

The benefits described in your booklet-certificate (Booklet) are provided under a group insurance policy (Policy) issued by the Hartford Life Insurance Company or the Hartford Life and Accident Insurance Company (Insurance Company) and are subject to the Policy's terms and conditions. The Policy is incorporated into, and forms a part of, the Plan. The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Policy. The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy.

A copy of the Plan is available for your review during normal working hours in the office of the Plan Administrator.

1. **Plan Name**

   Group Long Term Disability Plan for employees of WAL-MART STORES, INC.

2. **Plan Number**

   501

3. **Employer/Plan Sponsor**

   WAL-MART STORES, INC.
   702 Southwest 8th Street
   Bentonville, AR 72716

4. **Employer Tax Identification Number**

   71-0415188

5. **Type of Plan**

   Welfare Benefit Plan providing Group Long Term Disability benefits.

6. **Plan Administrator**

   WAL-MART STORES, INC.
   702 Southwest 8th Street
   Bentonville, AR 72716

7. **Agent for Service of Legal Process**

For the Plan:

WAL-MART STORES, INC.
702 Southwest 8th Street
Bentonville, AR 72716

For the Policy:

Hartford Life and Accident Insurance Company
200 Hopmeadow St.
Simsbury, CT 06089

In addition to the above, Service of Legal Process may be made on a Plan trustee or the Plan Administrator.

8. **Sources of Contributions** - The Employer pays the premium for the insurance, but may allocate part of the cost to the employee. The Employer determines the portion of the cost to be paid by the employee.

9. **Type of Administration** -- The Plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the applicable Plan.

10. The Plan and its fiscal records are kept on a Policy Year basis.

11. **Labor Organizations**

None

12. **Names, Titles and Addresses of the principal place of business for each Trustee of the Plan**

None

13. **Plan Amendment Procedure**

The Employer reserves full authority, at its sole discretion, to terminate, suspend, withdraw, reduce, amend or modify the Plan, in whole or in part, at any time, without prior notice.

The Employer also reserves the right to adjust your share of the cost to continue coverage by the same procedures.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all Plan participants shall be entitled to:

1. **Receive Information About Your Plan and Benefits**

a) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual

report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

b) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary Plan description. The administrator may make a reasonable charge for the copies.

c) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

2. Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

3. Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If the Plan requires you to complete administrative appeals prior to filing in court, your right to file suit in state or Federal court may be affected if you do not complete the required appeals. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and

fees, for example, if it finds your claim is frivolous.

4. **Assistance with Your Questions**

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

CLAIM PROCEDURES

The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Policy. The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy.

Claim Procedures for Claims Requiring a Determination of Disability

Claims for Benefits

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 45 days after receipt of your properly filed claim. The time for decision may be extended for two additional 30 day periods provided that, prior to any extension period, the Insurance Company notifies you in writing that an extension is necessary due to matters beyond the control of the Plan, identifies those matters and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision may be tolled from the date on which the notification of the extension is sent to you until the date we receive your response to our request. If the Insurance Company approves your claim, the decision will

contain information sufficient to reasonably inform you of that decision.

Any adverse benefit determination will be in writing and include: 1) specific reasons for the decision, 2) specific references to the Policy provisions on which the decision is based, 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary, **4) a description of the review procedures and time limits applicable to such procedures,** 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal, and 6)(A) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either (i) the specific rule, guideline, protocol or other similar criterion, or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the denial and that a copy will be provided free of charge to you upon request, or (B) if denial is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Policy to your medical circumstances, or (ii) a statement that such explanation will be provided to you free of charge upon request.

Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must

complete this claim appeal process before you file an action in court. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 180 days from the date you received your claim denial. As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and

2. you may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Insurance Company will make a final decision no more than 45 days after it receives your timely appeal. The time for final decision may be extended for one additional 45 day period provided that, prior to the extension, the Insurance Company notifies you in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for decision shall be tolled from the date on which the notification of the extension is

sent to you until the date we receive your response to the request.

The individual reviewing your appeal shall give no deference to the initial benefit decision and shall be an individual who is neither the individual who made the initial benefit decision, nor the subordinate of such individual. The review process provides for the identification of the medical or vocational experts whose advice was obtained in connection with an initial adverse decision, without regard to whether that advice was relied upon in making that decision. When deciding an appeal that is based in whole or part on medical judgment, we will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual consulted in connection with the initial benefit decision, nor a subordinate of such individual. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) specific reasons for the decision, 2) specific references to the Policy provisions on which the decision is based, 3) a statement that you have the right to bring a civil action under section 502(a) of ERISA, 4) a statement that you may request, free of charge, copies of all documents, records, and other information relevant to your claim; 5)(A) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision on appeal, either (i) the specific rule, guideline, protocol or other similar criterion, or

(ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the decision on appeal and that a copy will be provided free of charge to you upon request, or (B) if the decision on appeal is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the decision on appeal, applying the terms of the Policy to your medical circumstances, or (ii) a statement that such explanation will be provided to you free of charge upon request, and 6) any other notice(s), statement(s) or information required by applicable law.

Claim Procedures for Claims Not Requiring a Determination of Disability

Claims/or Benefits

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 90 days after receipt of your properly filed claim. However, if the Insurance Company

determines that special circumstances require an extension, the time for its decision will be extended for an additional 90 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 180 days after your claim was received. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

However, any adverse benefit determination will be in writing and include: 1) specific reasons for the decision; 2) specific references to Policy provisions on which the decision is based; 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; 4) a description of the review procedures and time limits applicable to such, and 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal.

Appealing Denials a/Claims/or Benefits

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 60 days from the date

you received your claim denial As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and

2. you may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Insurance Company will make a final decision no more than 60 days after it receives your timely appeal. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 60 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 120 days after your appeal was received. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) specific

reasons for the decision and specific references to the Policy provisions on which the decision is based, 2) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim, 3) a statement of your right to bring a civil action under section 502(a) of ERISA, and 4) any other notice(s), statement(s) or information required by applicable law.

EXCERPTS FROM HARTFORD'S LETTER TO MS. HEIMESHOFF DATED NOVEMBER 21, 2005 (Second Circuit JA 168-169)

This letter is about your claim for Long Term Disability (LTD) benefits. We need more information to evaluate your claim.

On 10/21/05, 11/1/05, 11/8/05 and 11/21/05 we faxed a request to Dr. Saitta for clarification on your functionality. This will be our last request for the information needed to decide your Long Term Disability (LTD) claim. Your claim decision will be based on information presently in your file if more information is not received. This may result in termination or denial of your claim.

On page 14 of the Policy, it states "You will be paid benefits if, while insured under the group policy. you:

(1) become Totally Disabled;

(2) remain Totally Disabled throughout the Elimination Period;

(3) remain Disabled beyond the Elimination Period; and

(4) submit proof of loss satisfactory to The Hartford."

On page 20 of the Policy it states "Written proof of loss must be sent to The Hartford within 90 days after the start of the period for which The Hartford owes payment. After that, The Hartford may require

further written proof you are still Disabled. If proof is not given by the time it is due, it will not affect the claim if:

(1) it was not possible to give proof within the required time; and

(2) proof is given as soon as possible; but

(3) not later than 1 year after it is due, unless you are not legally competent.

...

The Hartford reserves the right to determine if proof of loss is satisfactory.

Sincerely,

John Wentworth, Senior Examiner

Hartford Life and Accident Insurance Co.

EXCERPTS FROM HARTFORD'S LETTER TO MS. HEIMESHOFF DATED NOVEMBER 29, 2005 (Second Circuit JA 167)

...

We cannot make a claim decision without this information because it is needed to determine if you meet the policy definition of Disabled. This delay is for matters beyond our control. If we get the information requested, we expect to make our decision within 30 days after receiving the information or advise you of the need to further extend the decision period.

...

Sincerely,

John Wentworth, Senior Examiner

Hartford Life and Accident Insurance Co.

HARTFORD'S ADVERSE BENEFIT DECISION LETTER DATED DECEMBER 8, 2005 (Second Circuit JA 163-164)

December 8, 2005

Julie E. Heimeshoff
18 Lulworth Lane
Bella Vista, AR 72715

Policy Holder:	Wal-Mart Stores, Inc.
Associate:	Julie E. Heimeshoff
Policy Number:	GLT024554

Dear Ms. Heimeshoff:

We are writing to you about your claim for Long Term Disability (LTD) benefits. These benefits are under the group insurance policy number OLT024554 for Wal-Mart Stores, Inc.

We have completed our review of your claim for benefits and have determined that you have failed to provide satisfactory Proof of Loss to The Hartford. Therefore, we have determined that you are not eligible for LTD benefits at this time.

On page 14 of the Policy, it states "You will be paid benefits if, while insured under the group policy, you:

1) become Totally Disabled;
2) remain Totally Disabled throughout the Elimination Period;

3) remain Disabled beyond the Elimination Period; and

4) submit proof of loss satisfactory to The Hartford.

Benefits accrue as of the first day after the Elimination Period and are paid monthly. No benefit will be paid for any day on which you are not under the care of a legally qualified Physician.

On page 20 of the Policy it states "Written proof of loss must be sent to The Hartford within 90 days after the start of the period for which The Hartford owes payment. After that, The Hartford may require further written proof you are still Disabled. If proof is not given by the time it is due, it will not affect the claim if:

1) it was not possible to give proof within the required time; and

2) proof is given as soon as possible; but

3) not later than 1 year after it is due, unless you are not legally competent.

The Hartford has the right to require as part of proof of loss:

1) your signed statement identifying all Other Income Benefits; and

2) proof satisfactory to The Hartford that you and your dependents have duly applied for all Other Income Benefits which are available.

After submitting proof of loss, you will be required to apply for Social Security disability benefits. if the Social Security Administration denies your eligibility for any such benefits, you will be required to follow the process established by the Social Security Administration to reconsider denial and, if denied again, to request a hearing before an Administrative Law Judge of the Office of Hearing and Appeals.

The Hartford reserves the right to determine if proof of loss is satisfactory.

We based our decision to deny your claim on policy language. All the papers contained in your file were viewed as a whole. This included:

1. LTD application completed by you and dated 08/22/05.
2. Letters to you dated 11/1/05 and 11/21/05.
3. Requests to Dr. Saitta for clarification on your functionality sent to him on10/21/05, 11/1/05, 11/8/05 and 11/21/05.

On 10/21/05, 11/8/05 and 11/21/05 we sent requests to Dr. Saitta for clarification on your functionality. We also sent you letters on11/1/05 and 11/21/05. To date we have not received this information. Therefore, it is our determination that you have failed to provide satisfactory Proof of Loss to The Hartford and we are unable to continue evaluating your LTD application.

The following information, not previously submitted, is necessary for a determination of your claim.

Specifically, a response from Dr. Saitta to our letter requesting clarification on your functionality. This information is necessary in order for The Hartford to assess your claim and determine if you meet the definition of Totally Disabled from your own occupation at Wal-Mart Stores, Inc. If you would like this information considered, we must receive it as soon as possible. Please send it to the claim office at the address shown on this letterhead.

"We reserve all rights and defenses available to us in making our determination."

The Employee Retirement Income Security Act of 1974 (ERISA) gives you the right to appeal our decision and receive a full and fair review. You may appeal our decision even if you do not have new information to send us. You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim. If you do not agree with our denial, in whole or in part, and you wish to appeal our decision, you or your authorized representative must write to us within one hundred eighty (180) days from your receipt of this letter. Your appeal letter should be signed, dated and clearly state your position. Along with your appeal letter, you may submit written comments, documents, records and other information related to your claim.

Once we receive your appeal, we will again review your entire claim, including any information previously submitted and any additional information received with your appeal. Upon completion of this

review, we will advise you of our determination. After your appeal, and if we again deny your claim, you then have the right to bring a civil action under Section 502(a) of ERISA.

Please send your appeal letter to:

Claim Appeal Unit
Benefit Management Services
Hartford Life Insurance Company
P.O. Box 2999
Hartford, CT 06104-2999

If you have any questions, please feel free to contact our office at (800) 492-5678, x64230. Our office hours are 8:00 AM to 8:00 PM EST, Monday through Friday.

Sincerely,

John Wentworth, Senior Examiner

Hartford Life and Accident Insurance Co.

EXCERPTS FROM HARTFORD'S LETTER TO KRAFCHICK LAW FIRM DATED MAY 31, 2006
(Second Circuit JA 130)

...

As stated in our 12/8/05 letter, we did not deny Ms. Heimeshoff's claim based upon the medical records not supporting her Disability. The reason for the denial was the fact that we were unable to get her attending physician to respond to our letters asking for clarification on her functionality, thus preventing us from determining if she continued to meet the policy definition of Disabled. We still have not received this clarification. In this case, a formal appeal does not need to be filed to reopen her claim. Our 12/8/05 letter states that we need a response from Dr. Saitta to our 10/21/05 letter asking if she can do sedentary work to re-open her claim. Once we receive it, we will re-open her claim.

...

Sincerely,

John Wentworth, Senior Examiner

Hartford Life and Accident Insurance Co

HARTFORD'S ADVERSE BENEFIT DECISION LETTER DATED NOVEMBER 26, 2007 (Second Circuit JA 131-135)

Klafchick Law Firm
Kristian Erik Soholm, Attorney at Law
2701 First Ave, Ste 340
Seattle, WA 98121-1123

Policy Holder:	Wal-Mart Stores, Inc.
Claimant:	Julie E. Heimeshoff
Policy Number:	GLT024554

Dear Mr. Soholm:

We have received the appeal that you submitted in connection with the above referenced claim for Long Term Disability (LTD) benefits. Please refer to our letter of 11/29/06 (copy attached) which listed the policy provisions that apply to this matter. That letter also listed the evidence contained in your client's claim file. We have again reviewed those items, along with the following specific information:

- Appeal Letter from you dated 5/24/07 and 9/26/07
- Fibromyalgia Literature
- Neuropsychological Report by Sheila Bastien dated 8/29/07 and 8/30/07
- Medical Letter from Garrett Goss Clinic dated 9/24/07
- Medical Note from Dr. Michael Saiita dated 8/25/07

- Letter from Everett Pacific Industrial Rehabilitation dated 9/4/07
- CPX report from Pacific Fatigue Laboratory dated 8/27/07 and 8/28/07
- Letters from Julie Heimeshoff dated 4/22/07
- Letter from Volker Heimeshoff dated 4/8/07
- Letter from Paula Stimmel undated
- Letter from Sherli Bums dated 8/5/06
- Letter from Kaylynn Jordan dated 4/24/07
- Letter from Carla Murray dated 4/24/07
- Independent Medical Reviews

As part of your appeal you have presented literature, additional medical information and letters from your client, family and friends. Also, you note disagreement with the claim handling, investigation and that your client should have been physically examined by an Independent Medical Professional.

In order to provide a fair and impartial appeal review, the claim file was examined.

The date of disability was 6/9/05 but your completed claim filing was 10/2/06, over a year later, an Independent Medical Examination would not have been a true example of your client's functionality. A physical examination would not support your client's level of functionality at the time of disability as it had been over a year between her date of disability and the final claim filing. Therefore, in order to medically clarify her condition and level of

functionality as of the 6/9/05 date of disability, your client's file was referred for Independent Medical Reviews by Specialists.

Your client's medical records were reviewed by a Board Certified Rheumatologist. The medical record supports your client retains the residual physical capacity to perform sedentary work, and therefore has the work capacity to perform her occupation. The basis of the impairment supported by the attending physicians is the subjective complaints of pain and fatigue that is reported to affect cognitive function.

The data fails to support severity. The assessment of the PBPCE which was performed by Dr. Theodore Becker, PhD. on 08/10/2006 was reviewed. The elevation in the pulse is consistent with deconditioning; however, it is not of a sufficient severity to preclude your client from performing sedentary work, nor does the elevation in the pulse support that she would fail from a work rehabilitation program. The routine recommendations for the treatment of fibromyalgia include exercise and life style modifications. There is no support in the record that your client would not tolerate, with adequate effort and training, a work hardening program to improve conditioning, and thereby improve work capacity. The residual physical capacity is sufficient for sedentary work occupations.

The effect of pain and the medication used to treat pain requires the recommendations of no working at unprotected heights, no driving a company vehicle,

no working with heavy machinery or safety sensitive materials. The recommendations are made to avoid safety risks to the claimant or others as a result of potential decreased cognitive function from the pain or the pain medications.

Your client, based on the medical record, would be independent, ambulating without assistive devices and retains the ability to sit, stand and walk, listen and talk. There are no restrictions on fine motor manipulation or computer entry work. She has subjective complaints of pain and fatigue; the symptoms were reportedly present since 1991, as per the outpatient note with Dr. Shayan Alam on 9/15/05. It is unclear whether the change in 6/05 that resulted in an inability to work was the same pain that dated to 1991 while she was working for 14 years (with pain).

Your client's medical records were also reviewed by a Board Certified Clinical Neuropsychologist. The records indicate she was reportedly diagnosed with Lupus in 1991 and with Fibromyalgia in 1994. The diagnosis of Lupus was doubted on comprehensive evaluation in 2005, with no evidence of the disease at that time. Ms. Heimeshoff apparently complained of a number of somatic problems including pain (multiple types), fatigue, problems with stamina, sleep, as well as difficulties with concentration and memory.

The notes suggested depression with psychopharmacologic treatment that was felt to have had little influence on her status. Ms. Heimeshoff reportedly enjoyed her job and attempted to

maintain work activities with the help of her family, friends, and understanding coworkers, but stopped working in 6/05. Developmental history was reported to be unremarkable with a mention of childhood speech problems, yet no note of subsequent sequelae and high school GPA = 3.87. The claimant's IQ was measured in 1973 and was reported to be 127 (unverified report, unspecified testing method).

In addition to problems noted above, the medical history was reportedly significant for asthma, gynecological problems with a hysterectomy, osteoporosis, pericarditis, gastrointestinal problems, temporomandibular joint dysfunction, and migraine headaches. Brain imaging was reported to be within normal limits.

Your client's mental health history was noted to be significant for marriage counseling during Ms. Heimshoffs first marriage. There have reportedly been several trials of treatment with antidepressant medications, with no apparent concomitant psychiatric or psychotherapeutic follow-up. There was a reported psychiatric evaluation as a part of Ms. Heimshoffs Mayo Clinic work-up in 2005 with reported indications of depression and anxiety symptoms and suggestions for pharmacotherapy and counseling/psychotherapy. There was no indication of ongoing psychiatric or psychotherapeutic follow-up.

Ms. Heimeshoff is reportedly being treated with long acting opioid analgesics as well as hypnotic medications. A neuropsychological assessment was stated to have been conducted on 9/13/07. Some of

the test scores were included in the report. Some cognitive symptom validity testing was done and reported to suggest adequate effort. Assessment of affect was limited to BDI-II which generated a score within the mildly depressed range, though it was interpreted as indicating "minimal depression". The examination of the report and test results suggested largely normal cognitive performance, with some weak and inconsistent scores. Performance on measures assessing speed of information processing was inconsistent with some of the simpler measures generating low scores, while more complex ones producing normal levels of performance. While measures of manual motor speed, and dexterity were in the mildly to moderately impaired range, Ms. Heimeshoff still demonstrated entirely normal performance with both hands on a complex task requiring efficient integration of spatial and motor functioning. Her attention and immediate memory performance was well within normal limits. Memory performance was weak, although the assessment was quite limited, based on one verbal and one non-verbal measure. Influence of emotional/personality status on current presentation was not sufficiently assessed, Symptom validity with regard to endorsement of complaints of somatic or emotional difficulties was not assessed.

Information relevant to the field of neuropsychology did not support the presence of notable restrictions or limitations. Results of the neuropsychological assessment generated largely normal findings with some variable and low scores.

The available data relevant to the field of neuropsychology do not indicate restrictions or limitations. The presence of problems is based on Ms. Heimshoff's subjective complaints. The neuropsychological assessment offered limited evaluation of cognitive and emotional functioning that does not rule out the influence of emotional factors such as possible somatoform disorder, or motivation for secondary gain. It may be noted that the presence of somatoform disorder does not rule out successful engagement in work activities. Ms. Heimeshoff is apparently being maintained on several medications including opiate analgesics and hypnotics. These medications would require restrictions from working with heavy machinery, driving a company vehicle, and no working at heights.

The neuropsychological evaluation results suggested a largely normal level of functioning with some variable and weak scores. Some areas of functioning were insufficiently addressed. Most importantly, assessment of "affective status" was based on a single brief inventory assessing depression and not containing any validity indicators. Affective and somatoform factors are likely influences in this case and necessitate comprehensive testing (e.g., MMPI-2). Assessment of learning and memory was quite limited with one measure in the verbal and one in the nonverbal domain. Some additional learning and memory-related information can be gained from other data, yet overall this testing seems insufficient.

There was some concern regarding test administration and scoring. "Word Memory Test" was not listed among the administered tests, yet was included among the test results with a reported "perfect score". If the examiner referred to the Green's Word Memory Test, it contains several indices and it is unclear which indicator was reported or which portions of this measure were administered.

With regard to interpretation, the examining neuropsychologist seems to have overemphasized some of the findings to suggest pathology without sufficient justification. For example, despite a very good, high average level score on the information sub test, a measure of fund of general knowledge, performance was felt to indicate cognitive slippage, some loss of remote memory, and confusion. The source of this interpretation was not clear. An error on the most difficult and commonly missed item of the Arithmetic subtest indicated "a problem with dyscalculia" despite a clearly normal overall score that was within the upper portion of the average range. "Organic-like reversals" were reported for the Digit Span subtest despite a normal level score, and common occurrence of reversal errors regardless of cerebral dysfunction. On the Tactual Performance Test, the three timed block placement trials were performed well within normal limits relative to Heaton (2004) age and education-stratified norms. In the report this performance was felt to suggest "tactual-perceptual problem with her left hand, or some difficulties in learning". In fact, this performance suggests good manual dexterity and speed of processing and normal procedural learning

over trials. One mildly impaired score on the Thurstone Verbal Fluency Test was felt to suggest "brain dysfunction/damage", despite good performance on several other measures sensitive to cerebral impairment. These limitations as well as some others place doubt on the examining neuropsychologist's conclusions.

Based on the Independent Medical Reviews by Specialists the medical evidence does not support the limitation that your client is unable to perform any level of work/no work capabilities. From review of the additional information provided on appeal along with review of the information previously in file, there is no medical or vocational evidence to refute our original decision. Therefore, the appeal review concludes that the weight of the medical and vocational evidence in our file supports that your client is able to perform at least sedentary full time work and her own occupation is identified within that capacity. Because she is employable in her own sedentary work, she is not disabled and the decision to deny LTD benefits was correct under the terms of the policy. This is our final decision and the file remains closed.

You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other' information relevant to your client's claim. You may bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 ("ERISA").

Sincerely, Robyn J. Cote, Appeal Specialist
Hartford Life and Accident Insurance Co.

STATUTE OF LIMITATIONS CAN START RUNNING BEFORE CLAIM ACCRUES[2]

(Posted September 24, 2012)

Patrick Begos

ERISA claim practitioners generally have the concept of exhaustion of administrative remedies engrained in our thought process. They know well that claimants are required to exhaust their administrative remedies before they can sue over a benefit determination. Given the focus on this exhaustion requirement, it may surprise some to know that, in many circuits, the statute of limitations clock can begin to run well before administrative remedies are exhausted.

We start with the fact that ERISA does not prescribe a limitations period for actions to recover benefits payable under a plan. Therefore, courts will apply the limitations period specified in the most analogous limitations statute for the state in which the action is brought. *See Burke v. PriceWaterHouseCoopers LLP Long Term Disability Plan*, 572 F.3d 76, 78 (2d Cir. 2009). Typically, this is the limitations period for breach of contract.

Most states permit parties to a contract (and specifically to an insurance policy) to shorten the limitations period. When it comes to disability insurance policies, most states have statutes

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[2] http://www.erisaclaimdefense.com/statute-of-limitations-can-start-running-before-claim-accrues/

requiring insurers to include in their policies a provision that legal actions cannot be brought after the expiration of three years after the time written proof of loss is required to be furnished. *Wetzel v. Lou Ehlers Cadillac Group Long Term Disability Ins. Program*, 222 F.3d 643, 647 (9th Cir. 2000) (Forty-two states, Puerto Rico and the Virgin Islands all have statutes requiring identical or virtually identical language in certain insurance contracts). Adding in the time permitted to file proof of loss (usually 90 days after the expiration of the elimination period, which could be anywhere from 90 to 180 days after the onset of disability), and these statutes typically would require litigation to be brought less than four years from the date of disability.

As discussed above, courts generally require claimants to exhaust administrative remedies before they can sue. Exhaustion of remedies requires filing proof of loss, complying with requests for information, obtaining a benefit determination, then administratively appealing and getting a benefit determination on review. So, the question arises, does the limitation clock start running when proof of loss is due, or when administrative remedies are exhausted? (There is also the question whether the clock starts running on the initial benefit denial, but we will not address that here).

Five circuits (2d, 6th, 7th, 8th and 10th) have held that the contractual limitations provision is enforceable, meaning that the limitations clock starts running when proof of loss is due, as long as the contractual limitations period is enforceable

under the law of the state where the action is pending. *Burke v. Pricewaterhouse-Coopers LLP Long Term Disability Plan* (We join the Fifth, Sixth, Seventh, and Eighth Circuits in upholding written plan terms including limitations periods which may begin to run before a claimant can bring legal action); *Rice v. Jefferson Pilot Fin. Ins. Co.*, 578 F.3d 450, 456 (6th Cir. 2009) ("Because the parties have not provided any reason to ignore the plain language of the contract, and because we cannot find one, we hold that the clear repudiation rule does not apply and that the language of the contract governs"); *Abena v. Metro. Life Ins. Co.*, 544 F.3d 880, 884 (7th Cir.2008) ("Abena still had seven months following the conclusion of the internal appeals process in which to file his suit in the district court. ... In these circumstances, application of the contractual limitations period is not unreasonable"); *Blaske v. UNUM Life Ins. Co. of Am.*, 131 F.3d 763, 764 (8th Cir 1997), cert. denied, 525 U.S. 812 (1998) ("If Mr. Blaske was entitled to benefits after the expiration of the one hundred eighty day exclusion period, his right to such benefits vested on September 28, 1992, and a three year statute would require suit by September 28, 1995. The policy is more liberal than the Minnesota Statute"); *Salisbury v. Hartford Life And Acc. Co.*, 583 F.3d 1245, 1249 (10th Cir. 2009) ("We are not persuaded, however, by ... reasons [advanced] for refusing to enforce the contractual limitations provision simply because the plan allowed the claimant's cause of action to accrue before the end of the administrative process").

The 5th Circuit arguably adopted this rule in *Harris Methodist Fort Worth v. Sales Support Servs. Inc.*

Employee Health Care Plan, 426 F.3d 330, 337-38 (5th Cir.2005) ("This plan requires that any action to recover benefits be commenced within 'three (3) years from the time written proof of loss is required to be given.' ... There is no dispute among the parties that three years is a reasonable time period"). But the court subsequently stated, in an unreported decision, that it had not been necessary to reach that question in Harris because the parties did not dispute the reasonableness of the limitations period. *Baptist Mem'l Hosp.—DeSoto Inc. v. Crain Auto. Inc.*, 392 F. App'x 288, 295 (5th Cir. 2010).

Only one circuit – the 4th – has squarely held that a contractual limitations period cannot start to run before administrative remedies are exhausted. *White v. Sun Life Assur. Co. of Canada*, 488 F.3d 240, 247 (4th Cir. 2007) (refusing to "permit an ERISA plan to start the clock ticking on civil claims while the plan is still considering internal appeals").

The 2d, 6th and 10th circuits expressly rejected the reasoning of *White*. In *Burke*, the 2d circuit explained:

Recently, the Fourth Circuit refused to enforce a policy-prescribed limitations period that would begin to run before a claimant may bring suit. White v. Sun Life Assurance Co. of Can., 488 F.3d 240, 247 (4th Cir.2007). The White court's concern, as in Mitchell, was the possibility a plan administrator would use the administrative process to "undermine[ ] and potentially eliminate[ ] the ERISA civil right of action." Id. The Fourth Circuit considered the DOL regulations but concluded, depending on the plan

limitations period, a plan administrator could "eat up the entire limitations period." Id. at 251. In light of a court's authority to determine the reasonableness of a policy-prescribed limitations period, however, and its authority to toll that period should the facts of a given case require such a result, that possibility does not trouble us.

The Fourth Circuit was convinced a "reasonableness" fact-dependant standard is unworkable as it would "run counter to the values of certainty and predictability ... of most accrual and limitations rules," and "be particularly incompatible with ERISA, given its written plan requirement." White, 488 F.3d at 250. Our holding enforces the written plan requirement in its entirety. Contrary to the Fourth Circuit's position, enforcing a policy-prescribed limitations period as written, including the date upon which it will begin to run, will provide clear notice to plan participants of the time in which they must bring suit: for example, in this case, three years from the date Burke was required to provide Defendants with Proof of Loss.

The 6th circuit stated in *Rice*:

Although there are situations in which a contractual accrual date for ERISA claims could be unreasonable, see White v. Sun Life Assurance Co. of Canada, 488 F.3d 240, 246 (4th Cir.2007), there is nothing in the language of the contract in this case to suggest that the contractual accrual date is unreasonable. The Jefferson Pilot plan provides a three-year limitations period, along with a fail-safe provision that an employee's application is

considered denied if no answer is received within ninety days, thus avoiding any situation in which the limitations period would prevent an employee from bringing suit. See id. at 247-48 (finding a contractual accrual date unreasonable because the statute of limitations could expire before an employee knew that his application was denied and thus before he could file suit in federal court). Because the parties have not provided any reason to ignore the plain language of the contract, and because we cannot find one, we hold that the clear repudiation rule does not apply and that the language of the contract governs.

The 10th circuit explained in *Salisbury*:

We recognize that a benefits claimant must pursue the administrative process to its conclusion before filing an ERISA suit. We are not persuaded, however, by White 's reasons for refusing to enforce the contractual limitations provision simply because the plan allowed the claimant's cause of action to accrue before the end of the administrative process. See 488 F.3d at 246-53. Less drastic remedies that would take account of both the Plan's right to set a limitations period and the claimant's need to exhaust administrative remedies would be to allow a claimant at least a reasonable time after exhaustion of administrative remedies or to apply equitable tolling during the pendency of the administrative review process. See Wilkins, 299 F.3d at 949; see also Doe, 112 F.3d at 876 ("[I]f the defendant through representations or otherwise prevents the plaintiff from suing within the limitations period, the plaintiff may add to the remaining limitations

period the entire period during which the defendant's action was effective in delaying the suit."). But we need not decide in this case whether to endorse such remedies. The parties do not raise the issue, and in any event, Mrs. Salisbury filed her lawsuit more than three years after Hartford's September 19, 2003, denial of her administrative appeal.

As of the date of this post, the 1st, 3d, 9th, 11th and DC circuits have not directly addressed this issue.

The courts enforcing the contractual limitations provisions generally all recognize that, if the contractual limitation gave a claimant an unreasonably short time to file suit after administrative remedies were exhausted, a court could equitably extend that claimant's time to sue. The 4th circuit, in contrast, precluded any enforcement of the contractual limitation because it might be unreasonable in some situations.

LIMITING ERISA'S LIMITATIONS PERIOD THROUGH THE USE OF CONTRACTUAL ACCRUAL DATES[3] (April 2012)

Aaron A. Reuter

We have previously reported on how the federal discovery rule – pursuant to which claims for benefits do not accrue until the participant could reasonably have discovered the claim – can require plans to defend the merits of dated claims. Recently, there have been some helpful developments with respect to pension plan claims, insofar as courts have recognized that a claim may accrue at the time of retirement and, in some cases, even before retirement. Outside the pension plan context, efforts to protect plans have taken the form of contractual provisions that not only narrow the limitations period, but also prescribe when the claim accrues for statute of limitations purposes. Although most circuits have enforced such contractual provisions, there are some holdouts. As discussed below, courts that have invalidated contractual accrual provisions do so out of the misplaced belief that because federal law, rather than state law, governs the accrual of a cause of action, a contractual limitations period cannot apply. Because there is in fact no support for this distinction, it is hoped that these courts will eventually change course and a consensus will develop in favor of the enforcement of contractual accrual provisions.

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[3]http://www.proskauer.com/publications/newsletters/erisa-litigation-newsletter-april-2012/

ERISA's Rules on Statutes of Limitations

A starting point in the defense of ERISA lawsuits is to determine whether a plaintiff's claim is time-barred by the applicable statute of limitations. Because ERISA does not provide a statute of limitations for non-fiduciary claims, like a claim for benefits under ERISA Section 502(a)(1)(B), 29 U.S.C. 1132(a)(1)(B), courts "borrow" the state statute of limitations that is most analogous to a plaintiff's non-fiduciary ERISA claim. Courts do not, however, "borrow" the accrual date from state law. Irrespective of the source of a statute of limitations, the accrual date for a federal claim is governed by federal law.

Courts utilize the federal "discovery rule" to determine the accrual date for an ERISA benefits claim. The rule generally provides that a statute of limitations begins to run when a plaintiff discovers or should have discovered the injury that forms the basis of his claim. In the ERISA context, the rule has evolved to the so-called "clear repudiation rule," pursuant to which a non-fiduciary cause of action will accrue when a claim for benefits has been denied. The "clear repudiation rule" does not require that a *formal* denial occur. Rather, a cause of action accrues when a fiduciary repudiates a claim for benefits and that repudiation is clear and made known to the beneficiary.

Contractual Limitations Periods

The fact that courts will borrow from state law to determine the limitations period does not prevent

parties from contracting for a shorter statute of limitations period. Federal courts will generally enforce contractual statutes of limitations for benefit claims, so long as they are not "manifestly unreasonable." They are less consistent, however, in enforcing contractual accrual provisions, even when these provisions appear alongside the language setting forth the length of the limitations period. The circuits have been divided on this issue and, as discussed below, one circuit appears to have rulings that contradict each other.

The Fourth and Ninth Circuits have refused to enforce accrual provisions derived from ERISA plan statute of limitations language and will instead apply the "clear repudiation rule." In *White v. Sun Life Assurance Co. of Canada*, the Fourth Circuit specifically refused to enforce a contractual accrual date that began upon the date proof of loss was required to be furnished. The court not only disapproved of the application of the contractual accrual date in the case before it, but also refused to adopt a case-by-case, fact-intensive assessment of the reasonableness of the accrual provision, reasoning that such an approach "would impose upon courts a federal common law methodology less compatible with the ERISA framework than the familiar accrual rule that federal courts have presumptively applied." In so ruling, the court relied on the Ninth Circuit's reasoning in *Price v. Provident Life & Accident Insurance Co.* and stated that contractual accrual rules "create incentives for plans to use their governing documents to undermine their participants' civil claims . . . by making claims accrue when proof of loss was due and allowing the

statute to expire before a plan participant knew that his claim had been denied."

Contrasting the rulings by the Fourth and Ninth Circuits are those in the Second, Sixth, Seventh, and Eighth Circuits, which have enforced accrual dates contained in plan documents similar to those rejected by the *White* and *Price* courts. These courts reasoned that so long as the entire statute of limitations provision, including both the temporal and accrual elements, was reasonable, there was no reason not to apply and enforce the contractual terms on accrual dates. These courts also concluded that their approach was consistent with the principle that courts not re-write unambiguous contractual terms in such a way that a plan administrator could not anticipate when a suit would be brought.

Confusion in the Third Circuit

The Third Circuit's decision in *Miller v. Fortis Benefits Insurance Co.* is frequently cited by its district courts for the proposition that the "clear repudiation rule" should be used to determine the accrual date of a claim for benefits under ERISA, even where the ERISA plan at issue provides its own accrual date along with a temporal length for the contractual statute of limitations. In fact, however, the *Miller* court did not specifically hold that contractual accrual dates may not apply to ERISA benefit claims, and a later unreported decision from the Third Circuit suggests the opposite could be true.

In *Miller*, the plaintiff brought a claim for long term disability ("LTD") benefits, arguing that his LTD

benefits had been improperly calculated with a salary that was lower than the one he actually received. Both parties agreed that a six-year statute of limitations applied to the plaintiff's claim, but disputed the accrual date. The district court utilized the terms of the LTD plan to determine the accrual date and concluded that the complaint was time-barred. On appeal, the defendant cited the Seventh Circuit's decision in *Doe v. Blue Cross & Blue Shield United of Wisconsin*, for the proposition that "an agreed-upon limitations period, embodied in an ERISA plan, will control if the court considers it to be reasonable." *Miller*, 475 F.3d at 520. The Third Circuit, however, concluded that the defendant's reliance on *Doe* was misplaced because, it reasoned, the Seventh Circuit had only "determined the applicable statute of limitations for a non-fiduciary ERISA claim."

The Third Circuit went on to state:

As we have explained previously, the accrual date for federal claims is governed by federal law, irrespective of the source of the limitations period. To determine the accrual date of a federal claim, we utilize the federal "discovery rule" when there is no controlling federal statute. Under this rule, a statute of limitations begins to run when a plaintiff discovers or should have discovered the injury that forms the basis of his claim. In the ERISA context, the discovery rule has been "developed" into the more specific "clear repudiation" rule whereby a non-fiduciary cause of action accrues when a claim for benefits has been denied.

The court did not discuss the contractual provision in the LTD plan and instead went through an extensive analysis of the "clear repudiation rule," concluding that the plaintiff's claim accrued on the date he first received a miscalculated benefit payment. Applying this rule, the Third Circuit affirmed the district court's ruling that the complaint was time-barred.

Insofar as *Miller* construed the Seventh Circuit's ruling in *Doe*, the decision is subject to challenge. The Seventh Circuit enforced a contractual statute of limitations provision that ran 39 months from the date of the services for which benefits are sought, declining to apply the federal "discovery rule." Then, in *Abena v. Metropolitan Life Insurance Co.*, 544 F.3d 880, 884 (7th Cir. 2008), the court reasoned that, under *Doe*, "a contractual limitations period is enforceable in an ERISA action so long as it is reasonable" and specifically upheld a contractual term that allowed "three years from the time the proof of Disability must be submitted in which to file suit." Thus, while the Seventh Circuit has never specifically addressed whether the federal "discovery rule" trumps a contractual accrual provision, it has enforced contractual accrual dates where the entire statute of limitations period was considered reasonable.

The Third Circuit has continued to reject contractual accrual provisions and instead utilize the federal "discovery rule" and the ERISA specific "clear repudiation rule," stating that "a non-fiduciary cause of action under ERISA 'accrues when a claim for benefits has been denied.'"

What about *Klimowicz*?

In an unreported decision that came after *Miller*, but did not reference it, the Third Circuit reasoned in *Klimowicz v. Unum Life Insurance Co. of America* that the proper start date for the contractual statute of limitations period in a plan document for a LTD claim was *either* at the time proof of claim was required as defined by the plan document in the statute of limitations provision *or* when the plaintiff received a "clear repudiation" that his benefits would end. The district court had used the contractual accrual date in order to calculate whether the plaintiff's claim was time-barred by the plan's statute of limitations. In affirming the district court's ruling and reasoning that the proper accrual date *could* be derived from the plan document, the Third Circuit appears to have refuted the reasoning of its prior opinion in *Miller*. No district court in the Third Circuit, however, has followed *Klimowicz's* logic and expressly enforced a contractual accrual date.

Proskauer's Perspective

The reasoning of the Second, Sixth, Seventh, and Eighth Circuits is more consistent with the enforcement of the contractual provisions of ERISA plans because these courts allow for the adoption of *both* reasonable temporal lengths and accrual dates for statute of limitations purposes. It seems illogical to only adopt one half of the provision; indeed, how can the reasonableness of a time period be established without considering when it starts?

While the *Miller* decision seems to follow the reasoning of the Fourth and Ninth Circuits, its decision in *Klimowicz* appears to find a middle ground. Where a contractual accrual provision is either unreasonable or not available, it makes sense to utilize the clear repudiation rule. Where, however, there is a reasonable contractual accrual provision, it should be adopted and applied along with the rest of the contractual statute of limitations provision.

The lack of uniformity among the courts on this issue is particularly unfortunate because it can provoke forum shopping. It is hoped, therefore, that the courts that have declined to enforce contractual accrual provisions will soon "see the light" and reverse course.

ERISA'S STATUTE OF LIMITATIONS FOR BENEFIT CLAIMS: WHERE TO BEGIN?[4] (July 2010)

Myron D. Rumeld, Russell L. Hirschhorn and Brian Neulander

For plan counsel, the defense of claims for benefits is often complicated by the rather pro-participant nature of ERISA's rules governing the statute of limitations. Typically, the applicable limitations period is a rather lengthy one that replicates the limitations period for state law contract claims. In some states, it is as long as fifteen years. To make matters worse, the claim typically does not accrue until after a participant files and is denied an administrative claim for benefits. In some contexts, particularly pension claims that are filed when a participant reaches retirement age, the claim itself may present issues that depend on information dating back to the participant's earlier years of active employment.

Plan designers have been able to alleviate somewhat the difficulties of defending dated claims by inserting shorter limitations periods into the plan documents. Courts have looked favorably on such provisions, provided that they are reasonable and communicated clearly. But these rules do not change the fact that, however short the limitations period is, the period ordinarily still will not begin to run until the administrative claim has been filed and

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[4]http://www.proskauer.com/publications/newsletters/erisa-litigation-newsletter-july-2010/

denied. One means to address this concern is with plan provisions that prescribe the period in which claims accrue. Recent case law addressing the enforceability of such provisions provides some hope that they may serve as a vehicle for further protecting plans from the difficulties, and exposure risks, of defending dated benefit claims.

Applicable Limitations Period for Benefit Claims

Because ERISA's civil enforcement scheme does not provide a statute of limitations for benefit claims under Section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), courts have universally borrowed the "most analogous" state statute of limitations, which in most cases is the state statute of limitations that governs written contracts. In New York, for example, courts apply the state's six-year contract statute of limitations. *See, e.g., Carey v. Electrical Workers Local 363 Pension Plan*, 201 F.3d 44, 46-47 (2d Cir. 1999). Some states and commonwealths have lengthier contract statutes of limitations, including Ohio, Puerto Rico and Illinois. *See Daill v. Sheet Metal Workers' Local 73 Pension Fund*, 100 F.3d 62, 65 (7th Cir. 1996) (ten-years); *Meade v. Pension Appeals & Review Comm.*, 966 F.2d 190 (6th Cir. 1992) (fifteen years); *Martinez v. Johnson & Johnson Baby Products, Inc.*, 184 F. Supp. 2d 157, 159-62 (D.P.R. 2002) (fifteen years).

Courts have generally permitted plans to establish their own limitations period, which may be shorter than the period that would otherwise apply under state law. The only requirements are that the

contractual limitations period be "reasonable" and adequately described to participants, *i.e.*, the limitations period appears clearly in the plan or summary plan description. *See, e.g., Rice v. Jefferson Pilot Financial Insurance Co.*, 578 F.3d 450 (6th Cir. 2009); *Abena v. Metropolitan Life Insurance Co.*, 544 F.3d 880, 883 (7th Cir. 2008). In addition to shortening the limitations period that otherwise would apply, these rules also serve to unify the litigation process, in that the length of the limitations period will not be subject to the happenstance of where the participant resides or elects to commence a lawsuit.

Rules Governing the Accrual of Benefit Claims

Although state law determines the relevant statute of limitations period for benefit claims, federal common law determines when a claim for relief accrues. *See, e.g., Guilbert v. Gardner*, 480 F.3d 140, 148-49 (2d Cir. 2007); *Daill v. Sheet Metal Workers' Local 73*, 100 F.3d at 65. Under the federal discovery rule, "a plaintiff's cause of action accrues when he discovers, or with due diligence should have discovered, the injury that is the basis of the litigation." *Guilbert*, 480 F.3d at 149 (citing *Union Pacific Railroad Co. v. Beckham*, 138 F.3d 325, 330 (8th Cir. 1998)). In the ERISA context, the discovery rule has been construed to mean that a benefit claim accrues upon "a clear repudiation by the plan that is known, or should be known, to the plaintiff — regardless of whether the plaintiff has filed a formal application for benefits." *Carey*, 201 F.3d at 46-47; *see, e.g., Miller v. Fortis Benefits Insurance Co.*, 475 F.3d 516, 520-21 (3d Cir. 2007); *but see Hoover v.*

Bank of America Corp., 286 F. Supp. 2d 1326, 1333 n.12 (M.D. Fla. 2003) (requiring a formal application for benefits to be denied to trigger the statute of limitations and recognizing the tension between the standard adopted in this circuit and others), *aff'd without opinion*, *Hoover v. Bank of America Corp.*, 127 Fed. Appx. 470 (11th Cir. Jan. 5, 2005).

The circumstances in which a benefit claim accrues prior to a formal administrative denial have tended to be rare. Several courts have found that, in cases involving claims for wrongful denial of benefits resulting from a misclassification of a worker as an independent contractor, the limitations period commenced when it was made clear to the worker that he or she would not be eligible for benefits. *See, e.g.*, *Downes v. J.P. Morgan Chase & Co.*, No. 03 Civ. 8991, 2004 U.S. Dist. LEXIS 10510 (S.D.N.Y. June 8, 2004); *Brennan v. Metropolitan Life Insurance Co.*, 275 F. Supp. 2d 406, 409 (S.D.N.Y. 2003). Some courts also have found that the statute of limitations runs from the time a participant commences receipt of his or her benefit payments. *See, e.g.*, *Miller v. Fortis Benefits Insurance Co.*, 475 F.3d at 523; *Chuck v. Hewlett Packard Co.*, 455 F.3d 1026 (9th Cir. 2006). These decisions are not uniform in their approaches, however, and some involve independent facts and circumstances placing the participant on notice of the claim.

Outside these narrow contexts, there are virtually no published decisions finding that claims accrued prior to the exhaustion of administrative remedies. For that reason, many plan sponsors have engaged in efforts to accelerate the limitations period through

plan design. Thus, in addition to establishing a limitations period that is shorter than the one provided by state statute, some plans, particularly medical plans, have mandated that claims accrue on the date when proof of loss is required.

Over the past few years, several Circuit Courts have had the occasion to opine on whether a plan may establish its own accrual rules and have concluded, with one exception, that they should be enforced. In *Burke v. Price Waterhouse Coopers LLP Long Term Disability Plan*, 572 F.3d 76 (2d Cir. 2009), the Second Circuit held that a disability plan could require claimants to bring suit no more than three years after proof of loss was required to be submitted to the plan, irrespective of whether a claimant had exhausted his or her administrative remedies. The court reasoned that it should not rewrite a term of the contract when it is clear and unambiguous, as was the policy-prescribed limitations period at issue here, and that it was important that the plan administrator be able to anticipate that suit will be brought within the limitations period. The court also rejected plaintiff's argument that the plan could cause a "runout" of the limitations period by simply delaying administration of the benefit claims, because ERISA's claims regulations specify that a claim will be deemed denied if not timely decided. Finally, the court observed that its decision was in harmony with decisions from the Fifth, Sixth, Seventh and Eighth Circuits in upholding plan terms prescribing limitations periods that begin to run before a claimant can bring legal action. *See Abena v. Metropolitan Life Insurance Co.*, 544 F.3d at 880; *Harris Methodist Fort Worth v. Sales Support*

Services Inc. Employee Health Care Plan, 426 F.3d 330 (5th Cir. 2005); *Clark v. NBD Bank, N.A.*, 3 Fed. Appx. 500 (6th Cir. 2001); *Blaske v. UNUM Life Insurance Co. of America*, 131 F.3d 763 (8th Cir. 1997).

The Sixth Circuit subsequently reached the same conclusion in *Rice v. Jefferson Pilot Financial Insurance Co.*, 578 F.3d at 450. In so ruling, the court observed that the Supreme Court and the Sixth Circuit had both stated in the context of EEOC claims that "parties could conceivably ... agree[] to a contract" which set a different date of accrual for limitations periods than the statutory one. *Id.* at 455 (citations omitted). While the court acknowledged that there potentially are situations in which a contractual accrual date for ERISA claims would be unreasonable, it found that there was nothing in the language of the plan here to suggest this was the case, particularly since the plan expressly provided that a claim could be considered denied if there was no response to the claim within ninety days.

In contrast to these authorities, the Fourth Circuit held in *White v. Sun Life Assurance Co. of Canada*, 488 F.3d 240, 245 (4th Cir. 2007) that a plan provision requiring that an action be commenced within three years of the date that proof of loss was required, even if the claimant had not exhausted his or her administrative remedies, was not enforceable. The Fourth Circuit expressed concern that a plan administrator would use the administrative process to "undermine[] and potentially eliminate[] the ERISA civil right of action." It did not agree that the ERISA's claims regulations eliminated this concern

because, according to the court, depending on the plan limitations period, a plan administrator could "eat up the entire limitations period." In so ruling, the Fourth Circuit rejected an approach whereby courts could assess the reasonableness of the contractual limitations period and/or equitably toll the limitation on a case-by-case basis, finding that such an approach would "run counter to the values of certainty and predictability" of most accrual and limitations rules, and "be particularly incompatible with ERISA, given its written plan requirement."

Proskauer's Perspective

The ability to control the accrual date through plan design, as several Circuits have now recognized, could have far-reaching implications. Thus far, the cases enforcing such accrual rules have held only that plans can require that the claim accrue from the time proof of loss is due, as opposed to when the claim was exhausted. But these rulings could conceivably lead to the application of accrual rules in other contexts that could serve to more substantially reduce the ability of participants to resurrect stale claims. For example, pension plans that distribute annual statements of a participant's accrued benefits could provide that a challenge to these benefit calculations must be filed within a reasonable period after the receipt of these notices, or when the participant ceases active service, rather than at the point of retirement, when relevant information may no longer be readily accessible.

In short, while still in its nascent stages, the evolving law with respect to plan rules on the

accrual of benefit claims could one day serve as a tremendous benefit to plans trying to avoid the burdens and risks of defending benefit claims based on dated information and dated events.

COURTS STRUGGLE WITH WHEN LIMITATION PERIODS ACCRUE[5] (March 21, 2011)

Mark D. DeBofsky

Because the Employee Retirement Income Security Act ERISA statute lacks a specific limitation provision applicable to benefit claims, but the courts nonetheless enforce contractual limitations periods incorporated in benefit plans, courts frequently struggle with the question of when limitations periods accrue.

Novick v. Metro.Life Ins.Co., 2011 U.S.Dist.LEXIS 14505 (S.D.N.Y. Feb. 14, 2011) is an interesting new decision on how benefit plans can eliminate any doubt as to when the applicable limitations period accrues. There, the plaintiff, Karen Novick, a MetLife employee, became disabled in 2007 after receiving a tick bite and developing Lyme disease. She initially qualified for short-term disability benefits, but MetLife terminated the payments after a few months and Novick's appeal was unsuccessful. In 2009, however, she applied for long-term disability (LTD) benefits, but MetLife never responded to the application, triggering Novick's lawsuit. However, the insurer moved to dismiss the action on the grounds that the suit for the balance of short-term disability benefits was untimely and that Novick could not qualify for LTD if she did not

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[5] http://www.ddbchicago.com/articles-and-archives/articles-by-mark-d-debofsky/courts-struggle/

receive the full 26 weeks of short-term disability payments. The court denied the motion.

As to the short-term disability, the court found the denial letter failed to communicate a contractual provision containing a six-month limitation period to file suit and the court further determined the short-term disability plan's limitations period was unclear. The court pointed out that the ERISA regulations require the initial denial letter meet the following requirement:

> [(1)] [T]he plan administrator shall provide a claimant with written or electronic notification of any adverse benefit determination ... set[ting] forth, in a manner calculated to be understood by the claimant ... (iv) [a] description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the act following an adverse benefit determination on review.

29 C.F.R. § 2560.503-1(g)(1). Although no other case had ruled on the issue, the court interpreted the regulation to require disclosure of the applicable time limit. The court acknowledged the regulation is not clear on that point, however, the court ruled the ambiguity had to be construed in favor of the plan participant. The court further noted that its decision was consistent with *Solien v. Raytheon Long Term Disability Plan #590* , No. CV 07-456 TUC DCB, 2008 WL 2323915 (D. Ariz. June 2, 2008), which held that denial letters should set forth the time limit for filing a judicial action.

The court also cited secondary sources that recommended the inclusion of stated time limitations for bringing suit in all claim and claim appeal determinations. Because the plan failed to properly communicate the time limitation, rather than the plan's contractual limitation period, the court applied the six-year New York limitations period for actions on written contractual agreements and found the action timely.

The court also found the LTD claim could proceed. Although MetLife argued that exhaustion of short-term disability benefits was a condition precedent to eligibility for LTD benefits, the court examined the plan and determined that no such condition exists. But even if there were such a requirement, based on the allegations of the complaint, the court ruled that due to the claimed unlawfulness of the short-term disability termination, "a condition precedent may be excused if the party whose performance is predicated on that condition somehow blocks its occurrence." (citing *Cross & Cross Properties, Ltd. v. Everett Allied Co* ., 886 F.2d 497, 501 (2d Cir. 1989)) (other citations omitted). The court also found the plan language creating the so-called condition precedent ambiguous.

Both issues discussed by the court have tremendous significance. By mandating inclusion of the limitations deadline in the denial letter, the court has imposed a simple rule that would have eliminated several recent appellate rulings on contested limitations periods because the accrual of the limitations period was confusing. Even if the

wrong date is a communicated, so long as the plaintiff files suit prior to when the plan asserts the limitations period would expire, no plaintiff will be barred from proceeding with his or her claim.

Such a rule would avoid the situations that occurred in several recent appellate rulings. A recent ruling from the 7th U.S. Circuit Court of Appeals, *Abena v. Metropolitan Life Ins.Co.*, 544 F.3d 880 (7th Cir. 2008) held that the limitations period accrues while the claim appeal is pending. Even more recently, the 2nd U.S. Circuit Court of Appeals similarly ruled in *Burke v. Pricewaterhousecoopers LLP Long Term Disability Plan,* 572 F.3d 76 (2nd Cir. 2009) and the 9th U.S. Circuit Court of Appeals held in *Scharff v. Raytheon Co. Short Term Disability Plan,* 581 F.3d 899 (9th Cir. 2009) that the limitations period accrues prior to the exhaustion of presuit appeals; and in *Abdel v. U.S.Bancorp,* 457 F.3d 877 (8th Cir. 2006), the 8th U.S. Circuit Court of Appeals held that a limitations period accrued when an insurer notified the insured that a policy provision limiting the duration of benefit payments was applied to the claim, and that even though the insured appealed when the benefits terminated, the limitations period was not extended. However, in *White v. Sun Life Assur.Co. of Canada,* 488 F.3d 240 (4th Cir. 2007), the 4th U.S. Circuit Court of Appeals ruled the limitations period was tolled during the course of the claim appeal.

Given such inconsistency, and on account of the risk of uncertainty as to the accrual of the limitations period posed by the cases cited above, *Novick* is a particularly instructive ruling in its holding that the

communication of the date the limitations period would expire leaves no doubt as to the parties' rights.

On the second issue in *Novick*, the court recognized the risk to claimants of losing their right to even apply for LTD benefits when short-term disability benefits are wrongfully terminated prior to completion of the short-term disability benefit period. In ruling that receipt of the full period of short-term disability payments is not unambiguously a precondition to receipt of LTD benefits, it permits claimants to at least have the opportunity to pursue the benefits they were promised.

STATUTES AND REGULATIONS INVOLVED

Title 29, Code of Federal Regulations, Section 2560.503-f(3):

(f) Timing of notification of benefit determination—

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(3) Disability claims. In the case of a claim for disability benefits, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the plan. This period may be extended by the plan for up to 30 days, provided that the plan administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If, prior to the end of the first 30-day extension period, the administrator determines that, due to matters beyond the control of the plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the plan administrator notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the plan expects to render a decision. In the case of any extension under this

paragraph (f)(3), the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specified information.

Title 29, Code of Federal Regulations, Section 2560.503-h(2)(ii-iv) and (3)(i-v), (4):

Appeal of adverse benefit determinations—

(2) Full and fair review. Except as provided in paragraphs (h)(3) and (h)(4) of this section, the claims procedures of a plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures—

***

(ii) Provide claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

(iii) Provide that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall

be determined by reference to paragraph (m)(8) of this section;

(iv) Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

(3) Group health plans. The claims procedures of a group health plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless, in addition to complying with the requirements of paragraphs (h)(2)(ii) through (iv) of this section, the claims procedures—

(i) Provide claimants at least 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

(ii) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(iii) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including

determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(iv) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

(v) Provide that the health care professional engaged for purposes of a consultation under paragraph (h)(3)(iii) of this section shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and

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(4) Plans providing disability benefits. The claims procedures of a plan providing disability benefits will not, with respect to claims for such benefits, be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures comply with the requirements of paragraphs (h)(2)(ii) through (iv) and (h)(3)(i) through (v) of this section.

Title 29, Code of Federal Regulations, Section 2560.503-1(j)(1-3):

(j) Manner and content of notification of benefit determination on review. The plan administrator shall provide a claimant with written or electronic notification of a plan's benefit determination on review. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv). In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the claimant—

(1) The specific reason or reasons for the adverse determination;

(2) Reference to the specific plan provisions on which the benefit determination is based;

(3) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section;

OPPOSITION BRIEF

Supreme Court, U.S.
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MAR 11 2013
OFFICE OF THE CLERK

No. 12-729

IN THE

Supreme Court of the United States

JULIE HEIMESHOFF,

Petitioner,

v.

HARTFORD LIFE & ACCIDENT INSURANCE CO. AND WAL-MART STORES, INC.,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF IN OPPOSITION

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QUESTIONS PRESENTED

1. Whether a court should enforce a contractual limitations provision in an ERISA disability benefits policy requiring that any suit be brought within three years after the date proof of loss is due, where the claimant had actual knowledge of the limitations period and more than a year to file suit within that period after the final administrative denial of her claim.

2. Whether the court of appeals properly declined to address petitioner's argument that respondent violated regulatory notice requirements, where petitioner had actual notice of the contractual limitations period long before that period expired.

CORPORATE DISCLOSURE STATEMENT

Hartford Life and Accident Insurance Company is a wholly owned subsidiary of Hartford Life, Inc., which is a wholly owned subsidiary of Hartford Holdings, Inc., which is a wholly owned subsidiary of The Hartford Financial Services Group, Inc. The Hartford Financial Services Group, Inc. is a publicly traded corporation that has no parent corporation, and no publicly held corporation owns 10 percent of more of its stock.

Wal-Mart Stores, Inc. has no parent corporation, and no publicly held corporation owns 10 percent or more of its stock.

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STATUTES AND REGULATIONS

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IN THE

Supreme Court of the United States

No. 12-729

JULIE HEIMESHOFF,

Petitioner,

v.

HARTFORD LIFE & ACCIDENT INSURANCE CO. AND WAL-MART STORES, INC.,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF IN OPPOSITION

Respondents Hartford Life and Accident Insurance Company (Hartford) and Wal-Mart Stores, Inc. (Wal-Mart) submit this brief in opposition to the petition for a writ of certiorari.

STATEMENT

1. Wal-Mart established a disability benefits plan for its employees under a group disability insurance policy issued and administered by Hartford (the Policy). Under the Policy, Hartford pays benefits to qualifying Wal-Mart employees who become totally disabled. As relevant to petitioner's claim, the Policy defines total disability in part as an employee's inability,

due to sickness, to perform the essential duties of his or her occupation. App. 2a.[1]

Under the Policy, benefits for total disability become payable on the first day after an "Elimination Period." App. 3a-4a. As relevant here, the elimination period ends, and benefits become payable, when the employee has been totally disabled for 90 days or when Wal-Mart stops making salary continuation payments, whichever is later. App. 1a; Pet. App. 9. An employee seeking benefits under the Policy must provide Hartford with written "proof of loss" establishing his or her eligibility for benefits. Proof of loss is due "within 90 days after the start of the period for which The Hartford owes payment" (App. 5a)—that is, within 90 days after the end of the elimination period.[2]

If Hartford denies a claim in whole or in part, Hartford provides the claimant with a written notice giving reasons for the denial, describing any additional information necessary to substantiate the claim, and explaining the administrative review process. App. 6a. The claimant has a right to appeal the decision by submitting a written request for review, along with any additional documents the claimant wishes to offer in support of the appeal. *Id.* The Policy provides that Hartford will make a decision on the appeal within 60

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[1] Relevant provisions of the Policy are reproduced in the Appendix to this brief ("App.").

[2] A claimant's failure to meet the proof-of-loss deadline will not affect the claim for benefits if it was not possible to submit the proof within the required time and proof is given as soon as possible thereafter. App. 5a. After the deadline passes for submitting the written proof of loss, Hartford may require further documentation of the disability. *Id.*

days after receiving the request for review except in special circumstances, such as where a hearing is required, "but in no case more than 120 days after the request for review is received." *Id.*[3]

If Hartford denies the administrative appeal, the claimant may file a civil action challenging the denial of benefits under Section 502(a) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1132(a) (ERISA). The provisions of the Policy at issue here set time limits within which a claimant may bring such a suit. The Policy provides:

> Legal action cannot be taken against The Hartford:
>
> (1) sooner than 60 days after due proof of loss has been furnished; or
>
> (2) after the shortest period allowed by the laws of the state where the policy is delivered. This is 3 years after the time written proof of loss is required to be furnished according to the terms of the policy.

App. 7a. In the vast majority of States, insurance contracts are required by law to include proof-of-loss limitations language similar to this provision. *See Wetzel* v. *Lou Ehlers Cadillac Grp. Long Term Disability Ins. Program*, 222 F.3d 643, 647 n.5 (9th Cir. 2000) (listing statutes).

2. Petitioner Julie Heimeshoff began working for Wal-Mart in April 1986. Pet. App. 6. During her ten-

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[3] These deadlines were later revised in the Summary Plan Description (*see* Pet. App. 66) to reflect amendments to the governing regulations. *See* 65 Fed. Reg. 70,246 (Nov. 21, 2000).

ure, petitioner became eligible to participate in Wal-Mart's long-term disability insurance plan. *Id.* In January 2005, according to the Complaint, petitioner began to exhibit symptoms of fibromyalgia, including chronic pain and fatigue. *Id.* By May 2005, those symptoms had worsened, and petitioner had been diagnosed with several additional conditions. *Id.* On June 8, 2005, petitioner stopped working (*id.*), and on August 22, 2005, she submitted a claim to Hartford for long-term disability benefits (Pet. App. 7).

Because Wal-Mart continued paying petitioner's salary through September 8, 2005, *see* C.A.J.A. 126; Pet. App. 7 (noting 90-day salary continuation period), the elimination period under the Policy ended on that day, and any benefits owed would have become payable the next day, on September 9, 2005. *See supra* p. 2. Petitioner's written proof of loss was due 90 days later (App. 5a), on December 8, 2005.[4] On several occasions in October and November 2005, Hartford requested information from petitioner and her rheumatologist regarding petitioner's functionality in order to determine whether petitioner met the Policy's definition of total disability. Pet. App. 7, 72-74. Neither petitioner nor her rheumatologist responded to these requests. Pet. App. 8, 77-78.

On December 8, 2005, Hartford denied petitioner's claim for "failure to 'provide satisfactory Proof of Loss.'" Pet. App. 8; *see* Pet. App. 75-79. The denial let-

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[4] Overlooking the elimination period, petitioner's Complaint alleged that Hartford owed her payments as of June 8, 2005, when she stopped working. Pet. App. 14. As the district court noted, that would have made proof of loss due even earlier, by September 6, 2005. *Id.*

ter explained that Hartford could not determine whether petitioner was disabled within the meaning of the Policy without the information it had requested and stated that if petitioner wished to have that information considered, she must submit it as soon as possible. Pet. App. 77-78. Hartford advised petitioner of her right to appeal the denial by submitting a written request for review within 180 days. Pet. App. 78. Upon receipt of such a request, Hartford would "review the entire claim." *Id.* If Hartford "again den[ied] [the] claim," petitioner would "have the right to bring a civil action under Section 502(a) of ERISA." Pet. App. 79.

In May 2006, petitioner obtained counsel "'to assist her in acquiring the "satisfactory Proof of Loss" the Hartford was requesting.'" Pet. App. 8. On May 18, 2006, petitioner's counsel wrote to Hartford to confirm petitioner's intent to appeal the denial of benefits and to request a copy of the Policy and the administrative record. C.A.J.A. 138-139. On May 31, 2006, Hartford provided the requested materials, including a complete copy of the Policy, which contained the contractual limitations provision. C.A.J.A. 130. In its cover letter, Hartford explained that it would reopen petitioner's claim without any need for a formal appeal if it received the information it had previously requested. *Id.*; Pet. App. 80.

On October 2, 2006, petitioner submitted additional information. Pet. App. 8. Hartford reopened petitioner's claim and retained a rheumatology consultant, who evaluated the materials petitioner had submitted and spoke with petitioner's rheumatologist. Pet. App. 9. On November 29, 2006, after its consultant concluded that petitioner "'was able to perform the activities of her sedentary occupation,'" Hartford determined that petitioner did not meet the Policy's definition of total

disability and therefore did not qualify for benefits. *Id.*; *see* C.A.J.A. 127-129. The denial letter again advised petitioner of her right to pursue an administrative appeal by submitting a request for review within 180 days and of her "right to bring a civil action under Section 502(a) of ERISA" upon denial of that appeal. C.A.J.A. 129.

On May 24, 2007, petitioner sought an extension of time until September 30, 2007, to submit materials in support of an appeal. Pet. App. 14. Hartford agreed to that request and stated that if it received no additional information by that date, it would evaluate petitioner's appeal using the information currently in the file. Pet. App. 14-15. On September 26, 2007, petitioner submitted her administrative appeal. Pet. App. 9. With the assistance of two new doctors to review petitioner's records, Hartford conducted an administrative review of petitioner's claim. *Id.* At the end of that review, on November 26, 2007, Hartford concluded that petitioner was not totally disabled within the meaning of the Policy and issued a final denial of petitioner's claim. *Id.*; *see* Pet. App. 81-89. The denial letter advised petitioner of her right to "bring a civil action under Section 502(a) of [ERISA]." Pet. App. 89.

3. On November 18, 2010—nearly three years after Hartford denied petitioner's administrative appeal and nearly five years after petitioner's proof of loss was due—petitioner filed this action against Hartford and Wal-Mart. Petitioner alleged claims under ERISA challenging Hartford's denial of her claim for disability benefits. Respondents moved to dismiss on the ground that petitioner's complaint was time-barred under the Policy's contractual limitations provision. Pet. App. 5; *supra* p. 3.

The district court granted the motion to dismiss, holding that the Policy "unambiguously disallows legal action more than three years after the time written proof of loss is required to be furnished." Pet. App. 15. Even crediting petitioner's argument that proof of loss was not due until September 30, 2007—the date of the extension Hartford had agreed to for petitioner's administrative appeal (*supra* p. 6)—the district court held that petitioner's suit was untimely under the plain terms of the Policy. Pet. App. 15.[5] The court also rejected petitioner's argument that the contractual limitations period should not apply because Hartford had not provided notice of the limitations period in its denial letters. Pet. App. 15-18. Interpreting regulations implementing ERISA, the court held that "Hartford was not required to inform [petitioner] of the [Policy]'s limitations period for legal action in its benefits determination letter." Pet. App. 17-18.

On appeal, petitioner argued that the limitations period did not begin to run until Hartford denied her administrative appeal in 2007 because her cause of action did not accrue until she had exhausted her administrative remedies. In the alternative, petitioner argued that she was entitled to equitable tolling because Hartford had violated ERISA regulations requiring it

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[5] Contrary to petitioner's arguments below, neither Hartford's requests for additional information nor its agreement to extend the deadline for petitioner's administrative appeal altered the date proof of loss was due. *See* Resp. C.A. Br. 8-11, 29-32. Even if they did, however, the latest date proof of loss could have been due was September 30, 2007. Petitioner's suit was filed more than three years after that date and was therefore untimely under any calculation of the proof-of-loss deadline. Pet. App. 15.

to disclose the time limits for filing a civil action in its denial letters.

The U.S. Court of Appeals for the Second Circuit affirmed in an unpublished summary order. Pet. App. 1-4. With respect to petitioner's argument that her cause of action did not accrue until Hartford denied her appeal, the court relied on circuit precedent holding that an identical contractual limitations period in an ERISA plan could be enforced even where it began to run before the cause of action accrued. Pet. App. 3 (citing *Burke* v. *PriceWaterhouseCoopers LLP Long Term Disability Plan*, 572 F.3d 76 (2d Cir. 2009)). Applying the contractual limitations period, the court held that petitioner's action was time-barred because she filed it "more than three years after her proof of loss was due." *Id.*

As to petitioner's alternative argument, the court found it "need not address th[e] issue" of whether the ERISA regulations required Hartford to disclose the time limits for filing suit in its letters denying benefits. Pet. App. 4. The court noted that

> [Petitioner]'s counsel conceded in the district court and at oral argument that he had received a copy of the plan containing the unambiguous limitations provision long before the three-year period for [petitioner] to bring the claim had expired.

Id. In light of petitioner's actual knowledge of her right to sue and the time limits for doing so, petitioner was "not entitled to equitable tolling," regardless of whether Hartford had violated the regulations. *Id.*

REASONS FOR DENYING THE PETITION

I. PETITIONER'S ARGUMENTS CONCERNING THE ENFORCEABILITY OF THE CONTRACTUAL LIMITATIONS PROVISION DO NOT WARRANT REVIEW

It is undisputed that petitioner filed her ERISA suit long after the deadline established by the Policy's contractual limitations provision. Petitioner contends that the limitations provision should not be enforced as written because it began to run before her cause of action accrued at the conclusion of her administrative appeal. Contrary to the petition, however, every circuit but one to have considered the question has concluded that nothing in ERISA categorically forbids the enforcement of a contractual limitations period that begins to run before a claimant may bring suit. Only the Fourth Circuit has held otherwise, and its decision is an outlier: Since that court issued its decision, three other circuits have considered and rejected it.

Petitioner's case provides a poor vehicle to resolve the limited disagreement between the Fourth Circuit and other courts. None of the concerns that drove the Fourth Circuit to depart from the majority rule arose in petitioner's case. As the court of appeals noted, petitioner had actual knowledge of the limitations period at least as early as May 2006—more than two years before that period expired. Once petitioner filed her administrative appeal, after the deadline was extended at her own request, Hartford took only two months to complete its final review. And when Hartford issued its final denial letter, petitioner had more than a year remaining in the limitations period in which to file suit. Petitioner does not contend that Hartford unreasonably delayed its review of her appeal, and she does not contend that she had insufficient time to prepare her

suit before the limitations period expired. Enforcement of the contractual limitations provision was thus eminently reasonable in petitioner's case.

Moreover, even if application of a contractual limitations period could in theory be unreasonable in a particular case, that possibility does not warrant a holding that the limitations period is *per se* unenforceable. Courts that have rejected the Fourth Circuit's position, including the Second Circuit below, have recognized that equitable tolling or other relief may be appropriate where the administrative review process takes too long or a claimant lacks adequate notice of the time limits for filing suit. That is not the case here.

A. Petitioner Mischaracterizes The Nature And Degree Of Conflict Among The Circuits

As the court of appeals explained, ERISA does not contain a statute of limitations for suits challenging a denial of benefits. Pet. App. 2. Courts instead may borrow the limitations period "provided by the 'most nearly analogous state limitations statute.'" Pet. App. 3 (quoting *Burke* v. *PriceWaterhouseCoopers LLP Long Term Disability Plan*, 572 F.3d 76, 78 (2d Cir. 2009)). Where, however, the benefits plan contains a contractual limitations period, that provision is generally enforceable so long as it is reasonable. *See Order of United Commercial Travelers of Am.* v. *Wolfe*, 331 U.S. 586, 608 (1947).

Petitioner contends (at 2) that the lower courts have "adopted three conflicting approaches" to answer the question of "when ... an ERISA plan's statute of limitations begin[s] to run or accrue." As an initial matter, petitioner's focus on "accru[al]" is misleading. "Accrual"—in the sense of when a beneficiary's right to

bring suit under Section 502(a) arises—is a question of federal common law. Although the statute is silent on the matter, courts have generally held that "an ERISA action may not be brought in federal court until administrative remedies are exhausted." *Burke*, 572 F.3d at 79; *see also, e.g.*, *Chappel* v. *Laboratory Corp. of Am.*, 232 F.3d 719, 724 (9th Cir. 2000); *Bourgeois* v. *Pension Plan for Emps. of Santa Fe Int'l Corp.*, 215 F.3d 475, 479 (5th Cir. 2000); *Doe* v. *Blue Cross & Blue Shield United of Wis.*, 112 F.3d 869, 873 (7th Cir. 1997).

That is not the question the court of appeals decided. Here, the Policy includes a limitations provision that is not tied to the "accrual" of a beneficiary's cause of action. The Policy instead measures the deadline for filing suit from an event—the due date for submitting proof of loss—that precedes the time when a cause of action accrues. App. 7a (tying deadline for filing suit to "the time written proof of loss is required to be furnished according to the terms of the policy" without reference to an accrual). The only question presented in this case is whether that contractual limitations period should be enforced according to its terms.[6]

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[6] Where a policy includes no contractual limitations provision, leaving suits to be governed by a state statute of limitations, courts have adopted different approaches to determine when the limitations period begins to run on an ERISA benefits claim. *See, e.g.*, *Veltri* v. *Building Serv. 32B-J Pension Fund*, 393 F.3d 318, 324-325 (2d Cir. 2004) (discussing competing approaches). As explained in the text, however, that issue is also not presented in this case, which is governed by a contractual limitations provision that specifies the point at which it begins to run. *See, e.g.*, *Rice* v. *Jefferson Pilot Fin. Ins. Co.*, 578 F.3d 450, 455 (6th Cir. 2009) (noting precedent applying the "clear repudiation" rule of accrual to a claim governed by a state statute of limitations, but declining to apply that rule to a claim governed by a contractual limitations

Consistent with *Wolfe*, every circuit but one to have considered that question has held that a contractual limitations period like the one included in Hartford's Policy is enforceable unless its application would be unreasonable in a particular case. Petitioner concedes (at 2) that the Second, Sixth, Seventh, Eighth, and Tenth Circuits have adopted that rule. *See Salisbury* v. *Hartford Life & Accident Co.*, 583 F.3d 1245, 1248 (10th Cir. 2009) (rejecting beneficiary's argument "that the Plan's limitations period is unenforceable because it is triggered by the Proof of Loss due-date, not by the date of exhaustion of the process for administrative review"); *Rice* v. *Jefferson Pilot Fin. Ins. Co.*, 578 F.3d 450, 455-456 (6th Cir. 2009) ("Although there are situations in which a contractual accrual date for ERISA claims could be unreasonable, there is nothing in the language of the contract in this case to suggest that the contractual accrual date is unreasonable." (citation omitted)); *Burke*, 572 F.3d at 81 & n.5 (joining other circuits in "upholding written plan terms including limitations periods which may begin to run before a claimant can bring legal action," and rejecting the Fourth Circuit's contrary rule "[i]n light of a court's authority to determine the reasonableness of a policy-prescribed limitations period" on a case-by-case basis); *Abena* v. *Metropolitan Life Ins. Co.*, 544 F.3d 880, 884 (7th Cir. 2008) (holding that application of a contractual limitations period that began to run before the time for

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provision); *Mogck* v. *UNUM Life Ins. Co. of Am.*, 292 F.3d 1025, 1028 (9th Cir. 2002) (distinguishing state statute of limitations, for which an ERISA cause of action "'accrues either at the time benefits are actually denied, or when the insured has reason to know that the claim has been denied,'" from a contractual limitations period, which began to run at the time specified in the policy).

bringing suit was not unreasonable where beneficiary "still had seven months following the conclusion of the internal appeals process in which to file his suit in the district court"); *Blaske* v. *UNUM Life Ins. Co. of Am.*, 131 F.3d 763 (8th Cir. 1997) (enforcing a contractual limitations period requiring that suit be brought within three years after proof of claim was required). The First Circuit has similarly enforced a contractual limitations period requiring that any action be filed within three years after the due date for proof of disability, upon concluding that the period was reasonable. *See Santaliz-Rios* v. *Metropolitan Life Ins. Co.*, 693 F.3d 57, 60 (1st Cir. 2012), *petition for cert. filed*, 81 U.S.L.W. 3428 (U.S. Nov. 28, 2012) (No. 12-923).[7]

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[7] Other courts of appeals have addressed the enforceability of contractual limitations provisions without squarely addressing whether the period may begin to run before the time for bringing suit. The Third Circuit, in an unpublished opinion, has applied a contractual limitations period upon concluding that it was reasonable. *See Fontana* v. *Diversified Grp. Adm'rs, Inc.*, 67 F. App'x 722, 724 n.1 (3d Cir. 2003). Both the Fifth and Eleventh Circuits have similarly held that "contractual limitations periods on ERISA actions are enforceable, regardless of state law, provided they are reasonable," without specifically addressing the reasonableness of a limitations period that begins to run before the time for filing a judicial challenge. *Northlake Reg'l Med. Ctr.* v. *Waffle House Sys. Emp. Benefit Plan*, 160 F.3d 1301, 1303 (11th Cir. 1998); *see Harris Methodist Fort Worth* v. *Sales Support Servs. Inc. Emp. Health Care Plan*, 426 F.3d 330, 337 (5th Cir. 2005) ("Where a plan designates a reasonable, shorter time period, ... that lesser limitations schedule governs."); *Baptist Mem'l Hosp.-DeSoto Inc.* v. *Crain Auto. Inc.*, 392 F. App'x 288, 295 n.1 (5th Cir. 2010) ("Although *Harris Methodist* involved a three-year limitations period that began to run with the filing a completed claim, and thus before the claimant's ERISA cause of action accrued, we had no occasion to address this question because the parties did not dispute the reasonableness of the limitations period.").

These courts have recognized that ERISA plans are contracts and that "a court must not rewrite, under the guise of interpretation, a term of the contract when the term is clear and unambiguous." *Burke*, 527 F.3d at 81 (internal quotation marks omitted); *see also, e.g.*, *Rice*, 578 F.3d at 456.

Only one circuit has taken a different view. In *White* v. *Sun Life Assurance Co. of Canada*, 488 F.3d 240 (4th Cir. 2007), a divided panel of the Fourth Circuit held that a contractual limitations provision that begins to run before a judicial challenge can be filed is unenforceable *per se*. The panel majority reasoned that allowing the limitations period to begin running before a claimant had a right to bring legal action could allow the administrative remedy to undercut the remedy of judicial review. In particular, the *White* majority worried that "[b]enefit plans would have the incentive to delay the resolution of their participants' claims" in order to limit the time a claimant would have to seek judicial review. *Id.* at 247-248. Although the plan administrator had argued that any such delay could be addressed on a case-by-case basis, the majority rejected that approach on the ground that it would fail to give fair notice to claimants of when the time for seeking judicial relief would run. *Id.* at 248-251.

Chief Judge Wilkins dissented from that holding, *White*, 488 F.3d at 256-263, and three courts of appeals subsequently considered and rejected it, *see Salisbury*, 583 F.3d at 1248-1249; *Rice*, 578 F.3d at 456; *Burke*, 572 F.3d at 81 n.5. Although Petitioner argues (at 2, 10, 24) that the Ninth Circuit aligns itself with the Fourth Circuit in declining categorically to enforce contractual limitations periods that begin to run before the time for bringing suit, this argument relies on a misreading of *Price* v. *Provident Life & Accident Insurance Co.*,

2 F.3d 986 (9th Cir. 1993). In *Price*, the Ninth Circuit held that because the plan administrator had failed to notify the claimant that his claim had been denied, the limitations period did not begin to run until the claimant "had reason to know about the denial." *Id.* at 988. *Price* did not hold that a contractual limitations period like the one in Hartford's Policy could not be enforced if the beneficiary *was* properly apprised of the status of his claim and of his rights for review.[8]

The circuits that have rejected the Fourth Circuit's approach in favor of the majority rule have not overlooked the concerns raised in *White*. They have simply held that addressing those concerns does not require holding that contractual limitations periods are unenforceable *per se* when they begin to run before the time for bringing suit. Of the circuits in the majority, nearly all (including the Second Circuit) have recognized that a contractual limitations provision might be unenforceable or subject to equitable tolling in a particular case if it does not allow a reasonable amount of time to sue—for example, because the administrative appeal has

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[8] Nor has the Ninth Circuit read *Price* to establish such a rule. In *Mogck*, for instance, the court considered a plan that limited the period for filing a judicial challenge to three years from a request for "proof of claim." 292 F.3d at 1028. The court declined to enforce the provision because the plan administrator never made "an adequate request for the proof of claim," and therefore "never took the steps necessary to trigger the running of the contractual time limitation under the policy." *Id.* The court never cited *Price*, however, or otherwise suggested that the limitations period was unenforceable *per se*. The unpublished district court decisions petitioner cites (at 25-27) similarly do not warrant this Court's review. None holds that a contractual limitations provision that begins to run before the time for bringing suit is categorically unenforceable.

taken too long, or because the plan has failed to provide adequate notice to the claimant of her right to judicial review. The Tenth Circuit, for instance, rejected the Fourth Circuit's rule on the ground that "[l]ess drastic remedies" could "take account of both the Plan's right to set a limitations period and the claimant's need to exhaust administrative remedies." *Salisbury*, 583 F.3d at 1249. It identified at least two such remedies: "to allow a claimant at least a reasonable time after exhaustion of administrative remedies or to apply equitable tolling during the pendency of the administrative review process." *Id.* The Second Circuit similarly rejected the Fourth Circuit's rule on the basis of "a court's authority to determine the reasonableness of a policy-prescribed limitations period" and "to toll that period should the facts of a given case require such a result." *Burke*, 572 F.3d at 81 n.5.[9]

As these cases suggest, petitioner is wrong to characterize (at 2-3) the First Circuit's decision in *Ortega Candelaria* v. *Orthobiologics LLC*, 661 F.3d 675 (1st

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[9] *See also Rice*, 578 F.3d at 455-456 ("Although there are situations in which a contractual accrual date for ERISA claims could be unreasonable, there is nothing in the language of the contract in this case to suggest that the contractual accrual date is unreasonable." (citation omitted)); *Abena*, 544 F.3d at 884 ("We can certainly imagine circumstances in which the application of this provision would not be reasonable. ... But that is not what happened here."); *Doe*, 112 F.3d at 876 ("[I]f the defendant through representations or otherwise prevents the plaintiff from suing within the limitations period, the plaintiff may add to the remaining limitations period the entire period during which the defendant's action was effective in delaying the suit."); *LaMantia* v. *Voluntary Plan Adm'rs, Inc.*, 401 F.3d 1114, 1119 (9th Cir. 2005) ("Estoppel may apply ... against a party asserting a contractual limitations defense based on a specified time period in an ERISA disability plan.").

Cir. 2011), as establishing a "third approach" to the question whether contractual limitations periods should be enforced. *Ortega Candelaria* simply applied the principle that the other circuits in the majority have recognized by equitably tolling a contractual limitations period in a particular case where its application would have been unreasonable. *See id.* at 681 (explaining that the beneficiary "was materially misled" by the plan administrator). As noted, the First Circuit has more recently issued a decision following the majority rule. *See Santaliz-Rios*, 693 F.3d at 60.[10]

B. This Case Is A Poor Vehicle To Resolve The Limited Disagreement Between The Fourth Circuit And Other Courts

The Fourth Circuit's main concern in rejecting the reasonableness approach adopted by other courts of appeals was that such a rule would "make it impossible for plans to give their participants the notice of subsequent remedies required by law." *White*, 488 F.3d at 249. As the Fourth Circuit majority explained, its "quarrel [wa]s ... not with the ability of plans to set lim-

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[10] Petitioner also relies (at 2-3) on the district court's decision in *Novick* v. *Metropolitan Life Insurance Co.*, 764 F. Supp. 2d 653 (S.D.N.Y. 2011). That decision did not adopt a rule different from the Second Circuit's holding in *Burke*. Had it done so, it would of course be neither correct nor controlling. *Novick* simply recognized that a contractual limitations period that begins to run before the time for bringing suit may be unreasonable in particular circumstances, without holding that such periods are always unreasonable. *See id.* at 659-660 (holding that "[a]n ERISA policy's shorter limitations period will govern so long as that period is reasonable," but declining to enforce the limitations period because the plan administrator failed to provide adequate notice of the applicable time limit for filing suit).

its on the time in which claimants may seek review but with the lack of fair notice to claimants" under that framework. *Id.* at 250; *see id.* at 251 ("The case-by-case assessment ... lays waste to limitation periods' critical purpose of providing potential plaintiffs with meaningful notice of the timeliness of their actions and providing potential defendants an equally clear sense of when the time on possible claims has run."). Petitioner's argument, too, amounts to a disagreement with the Second Circuit and other courts of appeals as to what rule adequately vindicates the need for notice.

This case does not provide a suitable vehicle for the Court to evaluate the Fourth Circuit's concern for fair notice. The court of appeals found that petitioner had actual notice of the time limits for filing suit to challenge Hartford's benefits determination. Pet. App. 4. As soon as petitioner retained counsel in 2006, that attorney obtained a copy of the Policy, which clearly specified the contractual limitations period for bringing a judicial challenge. *See supra* p. 5. Petitioner's counsel admitted he knew of the limitations provision. Pet. App. 23-24. The court of appeals properly attributed that notice to petitioner herself. Pet. App. 4; *see, e.g.*, *Link* v. *Wabash R.R. Co.*, 370 U.S. 626, 634 (1962) (under "our system of representative litigation, ... each party ... is considered to have 'notice of all facts, notice of which can be charged upon the attorney'" (quoting *Smith* v. *Ayer*, 101 U.S. 320, 326 (1879))).

Indeed, had petitioner lacked notice of the Policy's limitations period, her case might not have come before this Court at all. Petitioner concedes (at 32) that the availability of equitable tolling in cases where notice is not provided "resolves the tension" between ERISA's exhaustion requirement and the possibility that a contractual limitations period might begin to run before

the end of the administrative review. And she concedes (*id.*) that the provision of adequate notice "permits insurers to draft the limitations provisions they desire." *See also* Pet. 3-4 (equitable tolling "satisfies ERISA[]" in cases where notice is lacking and "allows plans to write their own limitations provisions"); Pet. 11 (case-by-case remedy for notice violations is "consistent with" ERISA). In light of these concessions, it is not even clear whether petitioner agrees with the Fourth Circuit that a contractual limitations provision like the one in the Policy should be categorically unenforceable. To the contrary, petitioner contends (at 32) that the case-by-case approach applied in *Novick* and *Ortega Candelaria* is sufficient.

The Second Circuit follows precisely that approach. *See Burke*, 572 F.3d at 81 n.5 (recognizing court's authority to toll a contractual limitations period "should the facts of a given case require such a result"); *Veltri* v. *Building Serv. 32B-J Pension Fund*, 393 F.3d 318, 322-324 (2d Cir. 2004) (holding equitable tolling "appropriate" where defendant pension fund failed to provide notice of judicial review rights). The court of appeals simply held that petitioner was not entitled to equitable tolling because she had actual notice of the contractual limitations period. Pet. App. 4 (citing *Veltri*, 393 F.3d at 326).

This case also does not implicate the Fourth Circuit's concern that enforcing a contractual limitations provision like the one at issue here would give plan administrators an "incentive to delay the resolution of their participants' claims" to limit the claimant's time for filing suit. *White*, 488 F.3d at 247. Petitioner does not contend that Hartford engaged in any such delay tactics, nor could she. As noted, once petitioner filed her administrative appeal, Hartford took only two

months to resolve it. Moreover, when Hartford issued its final denial, petitioner had more than a year remaining in the limitations period within which to file suit. Petitioner does not deny that this was enough time to prepare her suit. As the Seventh Circuit has explained, an ERISA suit challenging a denial of benefits "is the equivalent of a suit to set aside an administrative decision," for which "ordinarily no more than 30 or 60 days is allowed." *Doe*, 112 F.3d at 875. The suit "is a review proceeding, not an evidentiary proceeding" or an "original lawsuit." *Id.* If application of the limitations provision would not have given a diligent claimant a reasonable amount of time to sue, the lower courts could have provided petitioner with relief. As in cases involving lack of notice, the Second Circuit has recognized "a court's authority to determine the reasonableness of a policy-prescribed limitations period" and to "toll that period" where a "plan administrator ... use[s] the administrative process to 'undermine[] and potentially eliminate[] the ERISA civil right of action.'" *Burke*, 572 F.3d at 81 n.5.

The concerns on which the Fourth Circuit rested its outlier rule thus are not present here, and this case accordingly provides a poor vehicle in which to evaluate the Fourth Circuit's anomalous approach. To the extent this Court wishes to review the merit of that approach, the issue arises frequently, and the Court should await an opportunity to decide the issue in a case that presents the full range of equities.

C. There Is No Error In The Second Circuit's Approach

In any event, the majority rule that the court of appeals applied in this case is manifestly correct. It is uncontested that under this Court's decision in *Wolfe*,

the parties to a contract may agree to a shorter limitations period than a statute would otherwise provide for disputes arising out of that contract. Petitioner thus conceded below that "under applicable law, Hartford could provide in its policy that a statute of limitations shorter than the state's period applied to a claimant's right to file a civil action for judicial review, so long as the policy provision is reasonable and unambiguous." Pet. C.A. Br. 17; *see also Wolfe*, 331 U.S. at 608 ("[I]t is well established that, in the absence of a controlling statute to the contrary, a provision in a contract may validly limit, between the parties, the time for bringing an action on such a contract to a period less than that prescribed in the general statute of limitations, provided that the shorter period itself shall be a reasonable period.").

This Court has also recognized that a cause of action may "accrue[] at one time for the purpose of calculating when the statute of limitations begins to run, but at another time for the purpose of bringing suit." *Reiter* v. *Cooper*, 507 U.S. 258, 267 (1993). Although the Court in *Reiter* did not "infer [that] odd result" in the absence of a specific indication in the statute at issue, the Policy here unambiguously specifies that the limitations period begins to run at a time different from the time when a claimant may bring a judicial challenge. App. 7a; *see Burke*, 572 F.3d at 79.

Moreover, there is no dispute that the Policy's limitations period complies with applicable state law. Connecticut law permits contracting parties to adopt a limitations period shorter than that provided by statute, as long as an aggrieved party can file suit within "one year from the time when the loss insured against occurs." Conn. Gen. Stat. § 38a-290; *see also Voris* v. *Middlesex Mut. Assurance Co.*, 999 A.2d 741, 746 (Conn. 2010).

Because it began to run from the time proof of loss was required, rather than from the time the loss occurred, the limitations period in the Hartford Policy was more than two years longer than state law required. Indeed, in the insurance context, "the vast majority of states ... *require* insurance contracts to include the proof of loss limitations language such as that at issue here." *Burke*, 572 F.3d at 81 (emphasis added); *see Wetzel* v. *Lou Ehlers Cadillac Grp. Long Term Disability Ins. Program*, 222 F.3d 643, 647 n.5 (9th Cir. 2000) (listing statutes).[11] As the dissenting opinion in *White* observed, this is for good reason: "Tying the limitations period to the date on which proof of claim is due serves the important function of ensuring that a civil action is not too remote in time from the events giving rise to the plaintiff's claim." 488 F.3d at 259 (Wilkins, C.J., dissenting).

Petitioner points to nothing in ERISA that precludes a limitations period like this one. Petitioner notes that ERISA provides for an integrated scheme of administrative and judicial review, *see Varity Corp.* v. *Howe*, 516 U.S. 489 (1996), and that it imposes fiduciary duties on plan administrators, *see Metropolitan Life Ins. Co.* v. *Glenn*, 554 U.S. 105 (2008). But she does not explain how a limitations provision like the one here offends these elements of the statutory scheme. Limitations periods are ubiquitous, and enforcing a reasonable limitations period does not "strip beneficiaries of their ability to file suit." Pet. 14. Nor is there any mer-

---

[11] Connecticut law requires that individual disability insurance policies include a provision stating that no legal action "shall be brought after the expiration of three years after the time written proof of loss is required to be furnished." Conn. Gen. Stat. § 38a-483(a)(11). Connecticut law contains no comparable requirement for group disability insurance.

it in petitioner's argument (at 3) that "lack of uniformity causes unequal access to judicial review." Whether contractual or statutory, limitations periods vary from plan to plan and jurisdiction to jurisdiction. By leaving the limitations period to be determined by state law or the terms of the contract, Congress plainly saw no concern with such variation.

Echoing the Fourth Circuit's decision in *White*, petitioner contends that applying a contractual limitations provision like the one here could undermine ERISA's two-tiered scheme of administrative and judicial review. But the notion that a plan administrator could manipulate the administrative review of a claim in order to deny the claimant an effective opportunity for judicial review is unfounded and does not justify a refusal to enforce the Policy according to its terms. ERISA regulations strictly limit the amount of time a plan administrator has to make an initial benefits determination and decide an administrative appeal. *See* 29 C.F.R. § 2560.503-1(f), (i). These deadlines prevent plan administrators from drawing out the administrative appeal in a manner that could preclude a diligent beneficiary from protecting his rights. As the Second Circuit has explained, the deadlines "requir[e] plan administrators to conclude appeals in a timely manner" and provide "protections ... should the plan administrator be dilatory." *Burke*, 572 F.3d at 80. The deadlines accordingly "support enforcing the contractual limitations provision." *Id.*; *see also White*, 488 F.3d at 260 (Wilkins, C.J., dissenting) (explaining that regulatory deadlines for review by the plan administrator leave the beneficiary with ample time in which to file a judicial challenge).

The Fourth Circuit majority concluded that these regulatory deadlines are insufficient to ensure the

availability of judicial review because the limitation period in a particular plan might be short enough that the administrative review could "eat up the entire limitations period." *White*, 488 F.3d at 251. But there is no reason that this possibility cannot be addressed through a case-by-case inquiry into the reasonableness of the limitations period and by application of equitable tolling to ameliorate occasional instances of unfairness. Moreover, as noted, contractual limitations provisions that run from the date proof of loss is due do not represent an effort by plan administrators to deny claimants their rights to judicial review, but instead reflect legal requirements in most States that policies must include such language. *Supra* p. 22.

In addition, contrary to the petition (at 23), ERISA's written-plan requirement supports the enforcement of limitations periods that are clearly specified in the contract. As this Court has explained, ERISA requires that benefit plans be established and maintained pursuant to a written instrument so that beneficiaries may "learn their rights and obligations at any time" by "examining the plan documents." *Curtiss-Wright Corp.* v. *Schoonejongen*, 514 U.S. 73, 83 (1995) (alteration in original) (emphasis omitted). At the same time, ERISA gives employers "large leeway to design disability and other welfare plans as they see fit," *Black & Decker Disability Plan* v. *Nord*, 538 U.S. 822, 833 (2003), and courts should not alter the terms of a plan to give participants rights that the sponsor did not provide. *See Burke*, 572 F.3d at 80 n.4, 81; *Rice*, 578 F.3d at 456.

The Fourth Circuit held, to the contrary, that consistent disregard of the written terms of a contractual limitations provision would better vindicate these goals of certainty and fairness than would a "sometimes-

enforcing approach to accrual provisions." *White*, 488 F.3d at 249. But it is difficult to see why. What the Fourth Circuit calls a "sometimes-enforcing approach" would better be called a "nearly-always-enforcing approach": as noted above, plan administrators are precluded by regulation from habitually cutting short the time for beneficiaries to bring suit, and in the rare instances when they do or when notice is lacking, courts can apply equitable tolling. To this narrow remedy, which respects as much as possible the written terms of benefit plans, the Fourth Circuit majority preferred a sweeping rule that does maximal violence to those written terms. That outcome is inconsistent with the law of contract generally and with ERISA's written-plan requirement in particular.

II. Petitioner's Arguments Concerning The Regulatory Notice Requirements Do Not Warrant Review

In the lower courts, petitioner sought equitable tolling of the contractual limitations period on the theory that Hartford had violated regulations requiring it to provide claimants with "[a] description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review." 29 C.F.R. § 2560.503-1(g)(1)(iv). In petitioner's view, this regulation required Hartford to notify petitioner in its denial letters not only of her right to seek judicial review, but also of the time limits for filing a judicial challenge to the benefit denial.

The court of appeals found it unnecessary to resolve whether this regulation required Hartford to include in its denial letters the date by which a judicial

challenge had to be filed. Pet. App. 4. Because petitioner had actual notice of the limitations provision in the Policy, the court concluded that petitioner was "not entitled to equitable tolling," regardless whether Hartford had violated the regulations. *Id.* (citing *Veltri*, 393 F.3d at 326 ("[A] plaintiff who has actual knowledge of the right to bring a judicial action challenging the denial of her benefits may not rely on equitable tolling notwithstanding inadequate notice from her pension plan.")).

Because the court of appeals did not pass on the question whether the regulation required Hartford's denial letters to include notice to petitioner of the time limits for filing suit, that question is not properly before this Court. *See, e.g., Zivotofsky ex rel. Zivotofsky* v. *Clinton*, 132 S. Ct. 1421, 1430 (2012) ("Ours is 'a court of final review and not first view.' Ordinarily, 'we do not decide in the first instance issues not decided below.'" (citations omitted)). Nor, as a result, is the question of what remedy is appropriate when a plan administrator violates any regulatory notice requirement.

In any event, petitioner's interpretation of the regulation lacks merit. As the district court recognized, section 2560.503-1(g)(1)(iv) requires two different types of notice: first, "[a] description of the plan's review procedures and the time limits applicable to *such* procedures" (emphasis added); and second, "a statement of the claimant's right to bring a civil action." Pet. App. 16-17; *see also* Pet. App. 54. The administrator need only specify the "time limits" for "the plan's review procedures," not for the filing of a civil action. *See* Pet. App. 17 ("That the regulation requires notification of time limits for plan review procedures but says nothing about time limits with respect to civil actions suggests that the [Department of Labor] did not intend to re-

quire such a time limit notification in the benefit determination.").

This interpretation of section 2560.503-1(g)(1)(iv), which applies to an initial adverse benefit determination, is supported by section 2560.503-1(j), which applies to an adverse benefit determination "on review" (*i.e.*, on administrative appeal). *See* Pet. App. 54. Subsection (j) requires a notice of denial on appeal to include "[a] statement describing any voluntary appeal procedures offered by the plan ... and a statement of the claimant's right to bring an action under section 502(a) of [ERISA]." 29 C.F.R. § 2560.503-1(j)(4) (Pet. App. 55). That regulation does not require disclosure of any time limit, and Hartford's final denial letter indisputably complied with the regulation by advising petitioner of her right to bring a civil action. Pet. App. 89. Because there is no requirement to include the litigation deadlines in the subsection (j) notice, which is the notice that actually triggers a claimant's right to seek judicial review, it makes little sense to read subsection (g)—which applies to the earlier determination—to require notice of those deadlines.

Moreover, if, as petitioner contends (at 36), a civil action under ERISA were deemed part of "the plan's review procedures," the requirement in section 2560.503-1(g)(1)(iv) to describe those procedures and their applicable time limits would be utterly unworkable. Litigation procedures vary widely and are not within the plan administrator's control. In this case, for example, in addition to Connecticut, petitioner might have chosen to bring this action in Arkansas, where she worked and resided, or Washington, where she was represented during administrative proceedings by an attorney in Seattle. Hartford could not possibly have listed in its denial letters the "review procedures" that

apply in every possible judicial forum.[12] In any event, as discussed above, the court of appeals found that petitioner knew of the limitations period contained in the Policy and accordingly did not reach the question whether the regulations required notice in the denial letters of the limitations provision and other litigation procedures.

CONCLUSION

The petition for a writ of certiorari should be denied.

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[12] Petitioner relies (at 36-37) on a footnote in the First Circuit's decision in *Ortega Candelaria*, 661 F.3d at 680 n.7. As petitioner concedes (at 36), however, that footnote was dictum; the court applied equitable tolling in that case because the plan administrator had failed to provide any notice of the claimant's right to sue. 661 F.3d at 680. Moreover, because the plan administrator "made no ... argument" about the scope of the regulations, the First Circuit had no occasion to consider the issues addressed above. *Id.* at 680 n.7. Petitioner also cites (at 32-34 & n.22) the district court's decision in *Novick*, 764 F. Supp. 2d 653, and the Ninth Circuit's decision in *Chappel*, 232 F.3d 719. But the district court in this case soundly rejected *Novick*'s reasoning. Pet. App. 15-18. And it correctly found *Chappel* inapposite, as that decision neither construed the regulation on which petitioner relies nor addressed how it would apply to a contractual limitations provision. Pet. App. 17; *see* 232 F.3d at 724-727.

Respectfully submitted.

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MARCH 2013

APPENDIX

APPENDIX

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
Hartford, Connecticut
(Herein called The Hartford)

CERTIFICATE OF INSURANCE
Under
Group Insurance Policies
GLT-205215 EFFECTIVE January 1, 1990
and
GLT-24554 EFFECTIVE September 1, 1988
Issued by
The Hartford
to
WAL-MART STORES, INC.
(Herein called The Policyholder)

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* * *

PLAN OF INSURANCE

* * *

Elimination Period: With respect to associates in Classes 1-3 the latter of:

(1) the first 90 days of any one period of Total Disability; or
(2) the end of your Employer sponsored salary continuation program.

* * *

The benefits described herein are those in effect as of January 1, 2000.

Total Disability or Totally Disabled[*] means that:

(1) during the Elimination Period; and
(2) for the next 12 months, you are prevented by:

(a) accidental bodily injury;
(b) sickness;
(c) Mental Illness;
(d) substance abuse; or
(e) pregnancy,

from performing the essential duties of your occupation, and are under the continuous care of a Physician and as a result you are earning less than 20% of your Pre-disability Earnings, unless engaged in a program of Rehabilitative Employment approved by us.

After that, you must be so prevented from performing the essential duties of any occupation for which you are qualified by education, training or experience.

"Your occupation" includes similar job positions with the Employer which may be offered to you, with a rate of pay 60% or greater of your Indexed Pre-disability Earnings.

Partially Disabled means that you are prevented by Disability from doing all the material and substantial duties of your own or any occupation on a full-time basis, except that:

(1) you are performing at least one of the material duties of your own occupation on either a full-time or part-time basis;

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[*] [The Policy's definition of Total Disability was amended by an endorsement effective January 1, 2005. The changes were minor and irrelevant to this petition.]

(2) you are under the continuous care of a Physician; and
(3) you are currently earning 20% to 80% less per month than your Indexed Pre-disability Earnings due to the same injury or sickness that caused the disability.

* * *

DEFINITIONS

* * *

Disability means any:

(1) accidental bodily injury;
(2) sickness; or
(3) pregnancy.

* * *

Elimination Period means the period of time you must be Totally Disabled before benefits become payable. See the Plan of Insurance for the Elimination Period.

* * *

BENEFITS

Article 1. Benefit Payment Due to Disability

You will be paid benefits if, while insured under the group policy, you:

(1) become Totally Disabled;
(2) remain Totally Disabled throughout the Elimination Period;
(3) remain Disabled beyond the Elimination Period; and
(4) submit proof of loss satisfactory to The Hartford.

Benefits accrue as of the first day after the Elimination Period and are paid monthly. No benefit will be paid for any day on which you are not under the care of a legally qualified Physician.

The Hartford will pay benefits until the first to occur of:

(1) the date you are no longer Disabled;
(2) the date you fail to furnish proof that you are continuously Disabled;
(3) the date you refuse to be examined, if The Hartford requires an examination;
(4) the date you die; or
(5) the date determined from the table below.

* * *

CLAIMS

Notice of Claim

You must give The Hartford written notice of claim within 30 days after the loss happens or starts. If notice cannot be given with that time, it must be given as soon as possible. Such notice must include your name, your address and the policy number.

Claim Forms

When The Hartford receives a notice of claim, you will be sent forms for providing The Hartford with proof of loss. The Hartford will send these forms within 15 days after receiving a notice of claim.

If The Hartford does not send the forms within 15 days, you may submit any other written proof which fully describes the nature and extent of your claim.

Proof of Loss

Written proof of loss must be sent to The Hartford within 90 days after the start of the period for which The Hartford owes payment. After that, The Hartford may require further written proof that you are still Disabled. If proof is not given by the time it is due, it will not affect the claim if:

(1) it was not possible to give proof within the required time; and
(2) proof is given as soon as possible; but
(3) not later than 1 year after it is due, unless you are not legally competent.

The Hartford has the right to require, as part of proof of loss:

(1) your signed statement identifying all Other Income Benefits; and
(2) proof satisfactory to The Hartford that you and your dependents have duly applied for all Other Income Benefits which are available.

After submitting proof of loss, you will be required to apply for Social Security disability benefits. If the Social Security Administration denies your eligibility for any such benefits, you will be required to follow the process established by the Social Security Administration to reconsider denial and, if denied again, to request a hearing before an Administration Law Judge of the Office of Hearing and Appeals.

The Hartford reserves the right to determine if proof of loss is satisfactory.

You will not be required to claim any retirement benefits which you may only get on a reduced basis.

* * *

Appeal of Claims Denied

If a claim for benefits is wholly or partly denied, you will be furnished with written notification of the decision. This written decision will:

(1) give the specific reason(s) for the denial;
(2) make specific reference to the policy provisions on which the denial is based;
(3) provide a description of any additional information necessary to prepare a claim and an explanation of why it is necessary; and
(4) provide an explanation of the review procedure.

On any denied claim, you or your representative may appeal to The Hartford for a full and fair review.

You may:

(1) request a review upon written application within 60 days of the claim denial;
(2) review pertinent documents; and
(3) submit issues and documents in writing.

A decision will be made by The Hartford no more than 60 days after the receipt of the request, except in special circumstances (such as the need to hold a hearing), but in no case more than 120 days after the request for review is received.

The written decision will include specific reference to the policy provisions on which the decision is based.

Legal Actions

Legal action cannot be taken against The Hartford:

(1) sooner than 60 days after due proof of loss has been furnished; or

(2) after the shortest period allowed by the laws of the state where the policy is delivered. This is 3 years after the time written proof of loss is required to be furnished according to the terms of the policy.

* * *

REPLY BRIEF

Supreme Court, U.S.
FILED
MAR 2 6 2013
OFFICE OF THE CLERK

No. 12-729

In The
Supreme Court of the United States

JULIE HEIMESHOFF,

Petitioner,

v.

HARTFORD LIFE & ACCIDENT INSURANCE CO., and WAL-MART STORES, INC.,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Second Circuit

PETITIONER'S REPLY TO BRIEF IN OPPOSITION

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ARGUMENT

This case warrants review because it presents a question that has split the circuits for more than a decade: can an ERISA plan enforce its contractual limitations period and start the clock running on a participant's civil claim before the participant has exhausted administrative remedies and can actually bring suit?

Five circuits have said "yes," crafting a rule that requires courts to perform, in each and every case, a "reasonableness" inquiry into whether, based on the specific facts, the contractual limitations period is reasonable. *See, e.g., Burke v. Price Water House Coopers LLP Long Term Disability Plan,* 572 F.3d 76 (2d Cir. 2009). Two circuits have said "no," holding that ERISA does not permit plans to impose a contractual limitations period that begins to run before a participant's civil claim has accrued, after the claimant exhausts her administrative remedies. *See, e.g., Price v. Provident Life & Accident Ins. Co.,* 2 F.3d 986 (9th Cir. 1993); *White v. Sun Life Assur. Co.,* 488 F.3d 240 (4th Cir. 2007). In those circuits which have yet to weigh in, the district courts have reached remarkable disagreement. *See, e.g., Tuttle v. Cigna Group Ins.,* 2012 U.S. Dist. LEXIS 47500, at *5-15 (S.D. Miss. Apr. 4, 2012); *Whittaker v. Hartford Life Ins. Co.,* 2012 U.S. Dist. LEXIS 166983, at *18-23 (E.D. Pa. Nov. 25, 2012); *Zorn v. Principal Life Ins. Co.,* 2012 U.S. Dist. LEXIS 3833, at *27-30 (S.D. Ga. Jan. 12, 2012).

Faced with this landscape, Respondent[1] has opted merely to peck at the margins – it does not dispute that a split exists, or that the question presented is of central importance to ERISA fiduciaries and beneficiaries alike. Resp.Br., at 10-17. Instead, it focuses much of its energy on trivializing the degree of disagreement among the circuits, arguing there is only "limited" disagreement between one "outlier" court and the rest. But even in this effort, Respondent mischaracterizes the caselaw and ignores key holdings.

Conceding the split, Respondent places most of its opposition eggs in a request for delay: it contends that this case presents a poor vehicle for review; that the Second Circuit failed to reach several relevant issues; and that the concerns at the heart of the dispute are not implicated here. Each argument fails.

I. The Split Is Well Defined and Review Is Appropriate Now.

Respondent contends the split among courts is merely one of "limited disagreement" between a majority and one "outlier." Not so.

A. Far from "limited," the disagreement over the enforceability of contractual limitations periods

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[1] Both Respondents (Hartford Life & Accident Ins. Co. and Wal-Mart Stores, Inc.) are referred to collectively, in the singular.

beginning to run before a claimant can file suit is clear and unconditional. In *White*, the Fourth Circuit flatly rejected the Second Circuit's "case-by-case reasonableness" approach as both "sharply at odds with ERISA" and completely unworkable. As the court explained, the Second Circuit's approach "flies in the face of the ERISA statutory framework" and "immerses courts in an extra-contractual and extra-statutory endeavor that is incompatible with ERISA's written-plan requirement." *White*, 488 F.3d at 246.

Instead, the Fourth Circuit embraced a "plain and unconditional" rule: contractual limitations periods that start the clock on a participant's claim before the participant can file suit are unenforceable under ERISA. The disagreement is therefore between a "case-by-case reasonableness" approach permitting these limitations periods (creating uncertainty) and a "plain and unconditional" rule invalidating them (providing more clarity and certainty). Nothing about this dispute is limited or narrow.

Nor – though Respondent does not contest this – is the disagreement trivial: it strikes at the core of ERISA's judicial review protections for participants and beneficiaries. In *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008), this Court took pains to emphasize that ERISA ensures that "a person denied benefits under an employee benefit plan [may] challenge that denial in federal court." *Id.* at 108. ERISA itself contains numerous provisions designed to ensure that beneficiaries have ready access to the courts, and this Court rejects interpretations of

ERISA that would strip away these protections. *See Varity Corp. v. Howe*, 516 U.S. 489, 513 (1996). *See also* 29 U.S.C. § 1001(b) ("providing for . . . ready access to the Federal courts").

Whether a plan can run the clock out on a claim before the claimant exhausts remedies and can ever get into court is simply another way of accomplishing what this Court has repeatedly said plans may not do – deny "ready access to the Federal courts." *Varity*, at 513.

B. Respondent tries another erroneous tack, arguing the Fourth Circuit is an "outlier." Resp.Br., at 9. But the Ninth Circuit shares the Fourth Circuit's view that contractual limitations provisions beginning to run before a participant can file suit are unenforceable. *See Price*, 2 F.3d at 988. The district courts in those circuits yet to weigh in have either recognized or outright embraced this rule. *See Amos v. Hartford Life & Accident Ins. Co.*, 2009 U.S. Dist. LEXIS 53287, at *3-4 (N.D. Ala. June 24, 2009); *Zorn*, 2012 U.S. Dist. LEXIS 3833, at *27-30; *Tuttle*, 2012 U.S. Dist. LEXIS 47500, at *5-15.

Respondent, unsurprisingly, tries to distinguish *Price* and *White*. It argues, for example, that *Price* is really about notice, not limitations periods, and that the court never really ruled on the enforceability of contractual limitations periods like the one at issue here. That is untrue. In *Price*, the plan relied on a contractual limitations period identical to this one, arguing the claim began running from the date of

proof of loss, not the final benefits denial. *See Price*, 2 F.3d at 988. The court refused to enforce the provision, holding the correct date at which a participant's claim begins to run is the date benefits are finally denied. *Id.*

In reaching this conclusion, the court could not have been clearer that it "reject[ed] the argument" that a plan could impose a different contractual accrual date or start the clock running before finally denying benefits. *Id.* To hold otherwise, the court warned, would allow the insurer to "wait for the statute of limitations to run" before telling the participant benefits were denied. Like the Fourth Circuit, the Ninth Circuit made clear "ERISA does not permit such a result." *Id.*

Unlike Respondent, most other courts have had no difficulty understanding that the Ninth Circuit's ruling in *Price* squares comfortably with the Fourth Circuit's in *White*. *See Rossi v. Partners Healthcare System, Inc.*, 2010 WL 5313551 (D. Mass. Oct. 6, 2010) (the "Ninth Circuit has reached a similar result" to *White*); *Holder v. Lowe's Long Term Disability Plan*, 2010 U.S. Dist. LEXIS 7109, at *6-7 (E.D. Tenn. Jan. 28, 2010) (viewing Fourth and Ninth Circuits as following the same rule); *Island View Residential Treatment Center, Inc. v. Bluecross Blueshield of Mass., Inc.*, 2007 U.S. Dist. LEXIS 94901, at *42 (D.Mass. Dec. 28, 2007) (same), *aff'd*, 548 F.3d 24 (1st Cir. 2008).

Indeed, the Fourth Circuit itself made clear that its approach followed the Ninth Circuit, which "has deemed" contractual accrual provisions like the one at issue here "unenforceable." *White*, 488 F.3d at 250. As *White* explained, *Price* concluded "such provisions create incentives for plans to use their governing documents to undermine beneficiaries' civil claims." *Id.* at 250. *Both* circuits, therefore, hold that "ERISA does not permit this result." *Id.*; *Price*, 2 F.3d at 988.

Other lower courts have also embraced the Fourth Circuit's approach. Respondents trivialize this too. suggesting this Court should not trouble itself with "unpublished district court decisions." Resp.Br., at 15, n.8. But these decisions arise within those circuits that have yet to decide the issue – all the more reason to grant review and provide guidance. In *Amos*, 2009 U.S. Dist. LEXIS 53287, for example, the court struggled to find the right rule to apply when faced with a contractual limitations period that, by its terms, would have started the clock well before the time the participant could have filed a lawsuit. The court recognized the Circuit split on what triggers the limitations period. *Amos,* 2009 U.S. Dist. LEXIS 53287, at *4. The court ultimately found "persuasive the rationale of the Fourth Circuit," refusing to enforce the limitations period, but only "in the absence of guidance from the Eleventh Circuit," which remains undecided. *Amos,* at *5. *See also Jeffries v. Trustee of Northrop Grumman Savings & Inv. Plan*, 169 F.Supp.2d 1380, 1383 (M.D. Ga. 2001). These cases all but invite this Court's resolution.

II. The Decision Below Contravenes ERISA.

A. ERISA has one basic purpose: "to protect . . . the interests of participants . . . and beneficiaries." 29 U.S.C. § 1001(b). The Second Circuit rejected that core principle when it embraced a rule that permits plans to run the clock down (or out) on a participant's judicial claim for benefits. As the Fourth Circuit recognized, allowing plans like Hartford to begin a limitations period before a participant can even file suit "runs afoul" of ERISA, by "undermin[ing] and potentially eliminat[ing] the ERISA civil right of action." *White*, 488 F.3d at 247. ERISA's remedial scheme – which contemplates an internal appeal followed, later, by judicial review – "does not permit an ERISA plan to start the clock ticking on civil claims while the plan is still considering internal appeals." *Id.* Yet that is exactly what the Second Circuit's rule allows, and what Respondent advocates here.

This Court has repeatedly rejected plan efforts to curtail this right. In *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008), the Court made clear that ERISA "permits a person denied benefits to challenge that denial in federal court." So too in *Varity*, where this Court emphasized that ERISA was designed to provide "ready access to the Federal courts." *Varity Corp. v. Howe*, 516 U.S. 489, 513 (1996). A plan may not – overtly or impliedly – impose a contractual regime that works to deny the ability of beneficiaries to gain federal court review of benefit decisions. Perhaps more pointedly in this context, an approach

that permits such an outcome will not survive scrutiny – a contractually-imposed limitation period that defeats a participant's access to courts contradicts ERISA and must be invalidated.

Respondent disagrees, arguing that contract enforcement is *the* principal purpose of ERISA, and therefore trumps any other consideration. Resp.Br., at 24. That contention fails on two levels. First, this Court has consistently held that "[t]he principal object of [ERISA] is to protect plan participants and beneficiaries," not to enforce plan terms. *Boggs v. Boggs*, 520 U.S. 833, 845 (1997). *See also MetLife v. Glenn*, 554 U.S. at 114 (the desire to protect beneficiaries "outweighed" other subsidiary purposes, including employers' freedom to set up benefit plans); *Varity*, at 513 (ERISA's ultimate purpose is "to protect the interests of participants and beneficiaries") (quoting basic purpose provision; alterations omitted).

Second, Respondent's proffered principle of categorical plan enforcement does not survive the Second Circuit's own rule. For a case-by-case reasonableness approach, courts would still be expected to depart from the plan's plain language. As the Fourth Circuit explained well, a "sometimes-enforcing approach . . . would disregard the written plan requirement" itself, since the "reasonableness" inquiry is "nowhere contained in [the] plan." *White*, 488 F.3d at 249. Contractual limitations periods would thus be enforced "sometimes, but not at other times, according to a standard neither contained in the plan document nor evident from its terms." *Id.*

Shifting gears, Respondent suggests that courts have adopted some safety valves to protect beneficiaries' judicial review rights and to comply with ERISA without resorting to a *per se* rule. According to Respondent, this includes allowing a claimant "at least a reasonable time **after exhaustion of administrative remedies** or to apply equitable tolling during the pendency of the administrative review process." Resp.Br., at 16 (quoting *Salisbury v. Hartford Life & Accident Ins. Co.*, 583 F.3d 1245, 1249 (10th Cir. 2009)). These work-arounds, however, suffer from several distinct problems.

First, as numerous courts and commentators have explained, this approach creates "as many problems as it would solve." *White*, at 248. True, as Respondent offers, courts could police the outer-bounds of reasonableness, by disregarding plan-specified accrual dates when a plan has taken so long to make a final determination that a claimant is left with no time to file suit. Resp.Br., at 15. But courts would have no easy way to determine how much of a compression of the claimant's limitation period is too much. As the Fourth Circuit noted, that approach itself imposes an extra-contractual inquiry, with far less clarity. After all, "whether an accrual provision was 'reasonable' with respect to a particular claimant would change each day that the plan did not issue a final decision." *Id.* at 248.

Respondent minimizes this concern, arguing in reality, the Second Circuit's approach is really a "nearly-always-enforcing approach," because administrators

would be unlikely to "habitually cut short the time" to bring suit. Resp.Br., at 25. That nice theory does nothing to satisfy the glaring inadequacies evident in the rule. Statutes of limitation need to be clear and unambiguous to all parties to eliminate hiding the ball and to effectuate the right of judicial review.

Second, a case-by-case reasonableness approach would "make it impossible for plans to give their participants the notice of subsequent remedies required by law." *White*, at 249. That is because "reasonableness is a subjective standard whose application to a particular claimant would shift over time." *Id.* By definition, this standard cannot be written into plans; thus, "[n]either a plan participant nor even a court could determine at the moment that a participant filed proof of claim whether his legal cause of action would accrue as provided under the plan's terms." *Id.*[2]

---

[2] Some courts *have* developed a workable approach for addressing the tension between the contractual limitations period and ERISA statutes and regulations. *Novick v. Metro. Life Ins. Co.*, 764 F.Supp.2d 653 (S.D.N.Y. 2011) sets out a roadmap for ERISA plans to meet "higher-than-marketplace" standards, applying minimum notice regulations to require that the insurer inform the participant, in the adverse determination letters and Summary Plan Description, of the time limits for filing a court action. Respondent mischaracterizes *Novick* as simply an application of the "reasonableness" rule. But *Novick* did more: it refused to enforce the plan's contractual limitations provision *because* MetLife had not complied with the notice requirements. *Id.* at 660-64. *See also Ortega Candelaria v. Orthobiologics LLC*, 661 F.3d 675, 680-81 & nn.7-8 (1st Cir. 2011). These decisions

(Continued on following page)

ERISA itself disfavors exactly this type of case-by-case approach. As but one example, litigation costs will increase because plans and claimants alike will have to fight over the reasonableness of the running of a limitations period in every case. This Court, on multiple occasions, has taken the opportunity to caution against rules that "interject other additional issues into ERISA litigation" that would "increase litigation costs." *Conkright v. Frommert*, 130 S.Ct. 1640, 1649-50 (2010). Standards creating "ad hoc exceptions" – like the Second Circuit's approach here – are particularly unfavorable because of the "uniformity problems that arise." *Id.* at 1650.

Equally disconcerting, the Second Circuit's opinion gives plans free reign to bypass with impunity key notice requirements provided for in ERISA. These notice obligations – set forth in 29 U.S.C. § 1133(1), (2), and, *e.g.*, 29 C.F.R. § 2560.503-1 – require, at a minimum, that plans tell beneficiaries of the appeal review time limits, and mandate that this information be included in both the initial adverse benefit determination and the Summary Plan Description. *See, e.g.*, 29 U.S.C. §§ 1001(a), (b); 1022(a);

---

have nothing to do with the reasonableness of the limitations period. Here, the Second Circuit's choice not to apply *Novick's* reasoning is problematic. Ostensibly, the court believed it could disregard *Novick* and the regulations because Petitioner had "actual knowledge" of the time limits simply because Petitioner's counsel received the plan among other documents. Suffice it to say, no case has *ever* held that actual knowledge relieves a plan from its statutorily-imposed minimum notice requirements.

29 C.F.R. §§ 2520.102-2(b), 2520.102-3(s), 2560.503-1(b)(2), (b)(3); (g)(1)(iv), (h); *MetLife v. Glenn*, 554 U.S. at 115 (imposing "higher-than-marketplace" standards on ERISA plans, referring to 29 C.F.R. § 2560.503-1).

By refusing to hold Respondent to its obligations under these requirements, the Second Circuit eviscerated them, and provided a blueprint for future plans to simply avoid higher-than-marketplace-duties completely. That decision cannot be squared with either the plain text of ERISA or its core objectives. At base, these notice requirements "protect . . . the interests of participants . . . and beneficiaries," 29 U.S.C. § 1001(b), by ensuring that beneficiaries know of, and act on, their rights to appeal an adverse benefit determination. Plans, and courts, simply may not disregard them, as Respondent and the Second Circuit did here.

III. This Case Presents an Ideal Vehicle for Review.

ERISA requires "efficiency, predictability, and uniformity." *Conkright v. Frommert*, 130 S.Ct. 1640, 1649 (2010). Absent Supreme Court action, judicial review of adverse benefit decisions will remain uneven and unpredictable for ERISA beneficiaries and plans, contrary to *MetLife v. Glenn*, *Varity*, and ERISA itself. The twin issues at the heart of this problem are straightforwardly presented in this case: whether a contractually-imposed limitations period

that starts the clock running before internal remedies have been exhausted and the beneficiary's civil claim accrues is enforceable, and whether a plan may ignore with impunity the notice requirements imposed by ERISA. Respondent agrees ERISA contractual limitations provisions are a thorny problem. There is little doubt that these issues have bedeviled courts and confused claimants for years. There is no reason to wait.

CONCLUSION

For the foregoing reasons, the petition should be granted.

Respectfully submitted,

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JOINT APPENDIX

RECORD
AND
BRIEFS

Supreme Court, U.S.
FILED
JUN 25 2013
OFFICE OF THE CLERK
SUPREME COURT, U.S.

No. 12-729

IN THE

Supreme Court of the United States

JULIE HEIMESHOFF,

Petitioner,

v.

HARTFORD LIFE & ACCIDENT INSURANCE CO. AND WAL-MART STORES, INC.,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

JOINT APPENDIX

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Petition For Certiorari Filed December 11, 2012
Petition Granted April 15, 2013

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Summary Order of the United States Court of Appeals for the Second Circuit, Sept. 12, 2012 1

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APPEAL, CLOSED, EFILE

RELEVANT DOCKET ENTRIES FROM THE United States District Court for the District of Connecticut (New Haven) CIVIL DOCKET FOR CASE #: 3:10-cv-01813-JBA

Heimeshoff v. Hartford Life and Accident Insurance Company et al

Date Filed	#	Docket Text
11/18/2010	1	COMPLAINT against Hartford Life and Accident Insurance Company, Wal-Mart Stores, Inc., filed by Julie Heimeshoff.(Fazekas, J.) (Entered 11/22/2010)
06/02/2011	27	MOTION to Dismiss by Hartford Life and Accident Insurance Company, Wal-Mart Stores, Inc..Responses due by 6/23/2011 (Begos, Patrick) (Entered: 06/02/2011)
06/02/2011	28	AFFIDAVIT re 27 MOTION to Dismiss Signed By Patrick W. Begos filed by Hartford Life and Accident Insurance Company, Wal-Mart Stores, Inc.. (Begos, Patrick) (Entered: 06/02/2011)
06/02/2011	29	Memorandum in Support re 27 MOTION to Dismiss filed by Hartford Life and Accident Insurance Company, Wal-Mart Stores, Inc.. (Begos, Patrick) (Entered: 06/02/2011)

06/23/2011	30	Memorandum in Opposition re 27 MOTION to Dismiss filed by Julie Heimeshoff. (Krafchick, Steven) (Entered: 06/23/2011)
06/23/2011	31	AFFIDAVIT re 30 Memorandum in Opposition to 27 Motion to Dismiss Signed By Steven P. Krafchick filed by Julie Heimeshoff. (Attachments: # 1 Exhibit part two) (Krafchick, Steven) Modified on 6/24/2011 to add link to Document #27 (Inferrera, L.). (Entered: 06/23/2011)
07/22/2011	37	REPLY to Response to 27 MOTION to Dismiss filed by Hartford Life and Accident Insurance Company, Wal-Mart Stores, Inc.. (Begos, Patrick) (Entered: 07/22/2011)
12/19/2011	43	Minute Entry for proceedings held before Judge Janet Bond Arterton: Motion Hearing held on 12/19/2011 re 27 MOTION to Dismiss filed by Wal-Mart Stores, Inc., Hartford Life & Accident Insurance Company. Taken Under Advisement Total Time: 1 hours(Court Reporter Sharon Montini,) (Torday, B.) (Entered: 12/19/2011)
01/20/2012	44	ORDER: Defendants' Motion 27 to Dismiss is GRANTED. Signed by Judge Janet Bond Arterton on 01/16/2012. (Budris, K.) (Entered: 01/20/2012)

01/23/2012	45	JUDGMENT entered in favor of Hartford Life & Accident Insurance Company, Wal-Mart Stores, Inc. against Julie Heimeshoff. For Appeal Forms please go to the following website: http://www.ctd.uscourts.gov/form.html. Signed by Clerk on 1/23/12. (Torday, B.) (Entered: 01/23/2012)
02/15/2012	46	NOTICE OF APPEAL as to 45 Judgment, 44 Order on Motion to Dismiss by Julie Heimeshoff. Filing fee $ 455, receipt number 0205-2404766. (Krafchick, Steven) (Entered: 02/15/2012)

RELEVANT DOCKET ENTRIES FROM THE UNITED STATES Court of Appeals, 2nd Circuit

Heimeshoff v. Hartford Life & Accident Insur

02/17/2012	1 8 pg, 95.65 KB	NOTICE OF CIVIL APPEAL, with district court docket, on behalf of Appellant Julie Heimeshoff, FILED. [530755] [12-651]
05/07/2012	40	CURED DEFECTIVE BRIEF AND JOINT APPENDIX [33], [37], [38], [39], on behalf of Appellant Julie Heimeshoff, FILED.[601368] [12-651]
05/15/2012	46 59 pg, 262.88 KB	BRIEF, on behalf of Appellee Hartford Life & Accident Insurance Company and WalMart Stores, Incorporated, FILED. Service date 05/15/2012 by CM/ECF. [610087] [12-651]
05/29/2012	52 36 pg, 144.1 KB	REPLY BRIEF, on behalf of Appellant Julie Heimeshoff, FILED. Service date 05/29/2012 by CM/ECF. [622653] [12-651]
09/10/2012	62	CASE, before BDP, RCW*, C.JJ., GLEESON, D.J., HEARD. [714539] [12-651]

09/13/2012	64 7 pg, 69.22 KB	SUMMARY ORDER AND JUDGMENT, affirming the judgment of the district court, by BDP, RCW, GLEESON, FILED.[718595] [12-651]

THE HARTFORD

Benefit Management Services
Atlanta Disability Claim Office
P.O. Box 1810
Alpharetta, GA 30023-1810
Facsimile (860) 392-0713

November 21, 2005

Julie E. Heimeshoff
18 Lulworth Lane
Bella Vista, AR 72715

Policy Holder: Wal-Mart Stores, Inc.
Associate: Julie E. Heimeshoff
Policy Number: GLT024554

Dear Ms. Heimeshoff:

This letter is about your claim for Long Term Disability (LTD) benefits. We need more information to evaluate your claim.

On 10/21/05, 11/1/05, 11/8/05 and 11/21/05 we faxed a request to Dr. Saitta for clarification on your functionality. This will be our last request for the information needed to decide your Long Term Disability (LTD) claim. Your claim decision will be based on information presently in your file if more information is not received. This may result in termination or denial of your claim.

On page 14 of the Policy, it states "You will be paid benefits if, while insured under the group policy, you:

(1) become Totally Disabled;

(2) remain Totally Disabled throughout the Elimination Period;

(3) remain Disabled beyond the Elimination Period; and

(4) submit proof of loss satisfactory to The Hartford."

On page 20 of the Policy it states "Written proof of loss must be sent to The Hartford within 90 days after the start of the period for which The Hartford owes payment. After that, The Hartford may require further written proof you are still Disabled. If proof is not given by the time it is due, it will not affect the claim if:

(1) it was not possible to give proof within the required time; and

(2) proof is given as soon as possible; but

(3) not later than 1 year after it is due, unless you are not legally competent.

The Hartford has the right to require, as part of proof of loss:

(1) your signed statement identifying all Other Income Benefits; and

(2) proof satisfactory to The Hartford that you and your dependents have duly applied for all Other Income Benefits which are available.

After submitting proof of loss, you will be required to apply for Social Security disability benefits. If the

Social Security Administration denies your eligibility for any such benefits, you will be required to follow the process established by the Social Security Administration to reconsider denial and, if denied again, to request a hearing before an Administrative Law Judge of the Office of Hearing and Appeals.

The Hartford reserves the right to determine if proof of loss is satisfactory."

Please have your physician return all information that we asked for within twenty one (21) days in order to avoid any delays in processing your claim for benefits.

If you have any questions, please feel free to contact our office at (800) 492-5678, x64230. Our office hours are 8:00 AM to 8:00 PM EST, Monday through Friday.

Sincerely,

John Wentworth, Senior Examiner
Hartford Life and Accident Insurance Co.

THE HARTFORD

Benefit Management Services
Atlanta Disability Claim Office
P.O. Box 1810
Alpharetta, GA 30023-1810
Facsimile (860) 392-0713

November 29, 2005

Julie E. Heimeshoff
18 Lulworth Lane
Bella Vista, AR 72715

Policy Holder: Wal-Mart Stores, Inc.
Associate: Julie E. Heimeshoff
Policy Number: GLT024554

Dear Ms. Heimeshoff:

We are reviewing your claim for Long Term Disability (LTD) benefits.

We have not received a response from Dr. Saitta to our letter requesting clarification on your functionality requested on 10/21/05, 11/1/05, 11/8/05 and 11/21/05.

We cannot make a claim decision without this information because it is needed to determine if you meet the policy definition of Disabled. This delay is for matters beyond our control. If we get the information requested, we expect to make our decision within 30 days after receiving the information or advise you of the need to further extend the decision period.

If you have any questions, please feel free to contact our office at (800) 492-5678, x64230. Our office hours are 8:00 AM to 8:00 PM EST, Monday through Friday.

Sincerely,

John Wentworth, Senior Examiner
Hartford Life and Accident Insurance Co.

THE HARTFORD

Benefit Management Services
Atlanta Disability Claim Office
P.O. Box 1810
Alpharetta, GA 30023-1810
Facsimile (860) 392-0713

December 8, 2005

Julie E. Heimeshoff
18 Lulworth Lane
Bella Vista, AR 72715

Policy Holder: Wal-Mart Stores, Inc.
Associate: Julie E. Heimeshoff
Policy Number: GLT024554

Dear Ms. Heimeshoff:

We are writing to you about your claim for Long Term Disability (LTD) benefits. These benefits are under the group insurance policy number GLT024554 for Wal-Mart Stores, Inc.

We have completed our review of your claim for benefits and have determined that you have failed to provide satisfactory Proof of Loss to The Hartford, Therefore, we have determined that you are not eligible for LTD benefits at this time.

On page 14 of the Policy, it states "You will be paid benefits if, while insured under the group policy, you:

1) become Totally Disabled;

2) remain Totally Disabled throughout the Elimination Period;

3) remain Disabled beyond the Elimination Period; and

4) submit proof of loss satisfactory to The Hartford.

Benefits accrue as of the first day after the Elimination Period and are paid monthly. No benefit will be paid for any day on which you are not under the care of a legally qualified Physician."

On page 20 of the Policy it states "Written proof of loss must be sent to The Hartford within 90 days after the start of the period for which The Hartford owes payment. After that, The Hartford may require further written proof you are still Disabled. If proof is not given by the time it is due, it will not affect the claim if:

1) it was not possible to give proof within the required time; and

2) proof is given as soon as possible; but

3) not later than 1 year after it is due, unless you are not legally competent.

The Hartford has the right to require, as part of proof of loss:

1) your signed statement identifying all Other Income Benefits; and

2) proof satisfactory to The Hartford that you and your dependents have duly applied for all Other Income Benefits which are available.

After submitting proof of loss, you will be required to apply for Social Security disability benefits. If the Social Security Administration denies your eligibility for any such benefits, you will be required to follow the process established by the Social Security Administration to reconsider denial and, if denied again, to request a hearing before an Administrative Law Judge of the Office of Hearing and Appeals.

The Hartford reserves the right to determine if proof of loss is satisfactory."

We based our decision to deny your claim on policy language. All the papers contained in your file were viewed as a whole. This included:

1. LTD application completed by you and dated 08/22/05.
2. Letters to you dated 11/1/05 and 11/21/05.
3. Requests to Dr. Saitta for clarification on your functionality sent to him on 10/21/05, 11/1/05, 11/8/05 and 11/21/05.

On 10/21/05, 11/1/05, 11/8/05 and 11/21/05 we sent requests to Dr. Saitta for clarification on your functionality. We also sent you letters on 11/1/05 and 11/21/05. To date we have not received this information. Therefore, it is our determination that you have failed to provide satisfactory Proof of Loss to The Hartford and we are unable to continue evaluating your LTD application.

The following information, not previously submitted, is necessary for a determination of your claim.

Specifically, a response from Dr. Saitta to our letter requesting clarification on your functionality. This information is necessary in order for The Hartford to assess your claim and determine if you meet the definition of Totally Disabled from your own occupation at Wal-Mart Stores, Inc. If you would like this information considered, we must receive it as soon as possible. Please send it to the claim office at the address shown on this letterhead.

"We reserve all rights and defenses available to us in making our determination."

The Employee Retirement Income Security Act of 1974 (ERISA) gives you the right to appeal our decision and receive a full and fair review. You may appeal our decision even if you do not have new information to send us. You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim. If you do not agree with our denial, in whole or in part, and you wish to appeal our decision, you or your authorized representative must write to us within one hundred eighty (180) days from your receipt of this letter. Your appeal letter should be signed, dated and clearly state your position. Along with your appeal letter, you may submit written comments, documents, records and other information related to your claim.

Once we receive your appeal, we will again review your entire claim, including any information previously submitted and any additional information received

with your appeal. Upon completion of this review, we will advise you of our determination. After your appeal, and if we again deny your claim, you then have the right to bring a civil action under Section 502(a) of ERISA.

Please send your appeal letter to:

Claim Appeal Unit
Benefit Management Services
Hartford Life Insurance Company
P.O. Box 2999
Hartford, CT 06104-2999

If you have any questions, please feel free to contact our office at (800) 492-5678, x64230. Our office hours are 8:00 AM to 8:00 PM EST, Monday through Friday.

Sincerely,

John Wentworth, Senior Examiner
Hartford Life and Accident Insurance Co.

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May 18, 2006

John Wentworth
Hartford Life and Accident Insurance Co.
Claim Appeal Unit
P.O. Box 2999
Hartford, CT 06104

RE: Our Client: Julie Heimeshoff
Your Insured: Wal-Mart Stores, Inc.
Claim No.: GLT024554
Date of Loss: 12/8/2005

Dear Mr. Wentworth:

We represent Julie Heimeshoff, who has a disability claim with Wal-Mart Stores, Inc. Please send all future correspondence in this matter to us. Also, please confirm the accuracy of the above-referenced claim number and advise us of any payments you have made to our client.

We have a copy of your letter to Ms. Heimeshoff, dated December 8, 2005. We understand that you have denied her Long Term Disability claim on the

basis of a failure to provide satisfactory Proof of Loss to the Hartford, specifically, The Hartford's request for clarification of her functionality. We also understand that you have given her notice that she has 180 days from the date she received your letter to appeal.

We are appealing Hartford Life and Accident Insurance Company's denial of Ms. Heimeshoff's long term disability benefits. We are requesting that you allow us to submit additional information in support of our client's claim. We ask that you provide us an additional one hundred eighty (180) days from our receipt of the requested complete claim record in order to submit information.

So that we can fully understand the claim and advise our client, please provide us with a complete copy of the administrative record relating to our client's claim for disability benefits. This should include the entire claim file with copies of any statements taken from our client, or others, regarding our eligibility for disability benefits; copies of all correspondence between our client and your company regarding this claim for disability benefits; a copy of the applicable disability policy; all applications for benefits completed by our client; all medical records received and/or reviewed regarding our client's claim for disability benefits; all medical evaluations pertaining to our client's qualification for benefits; all other expert consultants or internal evaluations of the client's physical condition, mental condition, or qualification for benefits; all documents relating to requests for disability benefits from Social Security or other agencies; all internal notes and evaluations; a copy of

policies and procedures governing handling of this claim; and any additional information you may have to assist us in evaluating this case fairly. We also request your underwriting file for this claim. An authorization for release of this information signed by our client is enclosed.

If you contend that this claim is governed by ERISA, please identify the plan administrator (name, address, phone number, fax number) and provide a copy of the Summary Plan Description or tell us the name, phone and fax numbers, and address of the person to contact to get the SPD. Also provide a copy of the insurance policy or policies applicable to our client's claim for disability benefits and a copy of Form 5500 filed with the Department of Labor.

In particular, if you believe this plan is governed by ERISA, we also request a copy of all documents, records, and other information relevant to our client's claim for benefits pursuant to 29 CFR 2560.503-1. This should include all documents, records or other information that was relied upon in making the benefit determination; that was submitted, considered, or generated in the course of making the benefit determination without regard to whether such document, record, or other information was relied upon in making the benefit determination; that demonstrates compliance with required administrative processes or safeguards; or that constitutes a statement of policy or guidance with respect to the plan concerning the denied benefit for our client's diagnosis, whether or not it was relied on in making the benefit determination. Furthermore it should include any internal rule,

guideline, protocol, or other similar criterion applicable to handling of this claim.

Whether or not you contend this claim is governed by ERISA, we also request that you tell us the amount of the monthly benefit our client will be entitled to if eligibility for benefits is established under the applicable policy or plan. Please let us know if there are any cost of living adjustments or other income deductions that you believe would apply.

We hereby request that you provide us with one hundred eighty (180) days from our receipt of the requested complete administrative record to submit additional information in support of our client's claim. If we do not hear from you to the contrary within fourteen (14) days, we will consider that as an agreement to this extension request.

We are currently investigating this case and its implications for our client. If you can respond to this letter within the next week or so, we are certain we can establish a cooperative working relationship with you to resolve this claim.

Very truly yours,

KRAFCHICK LAW FIRM

/s/ Steven P. Krafchick
Steven P. Krafchick

Encl.: Auth. for Release

THE HARTFORD

Benefit Management Services
Atlanta Disability Claim Office
P.O. Box 1810
Alpharetta, GA 30023-1810
Facsimile (860) 392-0713

May 31, 2006

Steven Krafchick
2701 First Ave.
#340
Seattle, WA 98121

Policy Holder: Wal-Mart Stores, Inc.
Associate: Julie E. Heimeshoff
Policy Number: GLT024554

Dear Mr. Krafchick:

This letter is about your claimant's claim for Long Term Disability (LTD) benefits. I am in receipt of your 5/19/06 letter. I have attached a copy of Ms. Heimeshoff's LTD policy, her LTD claim file, and copy of our internal notes. The Wal-Mart policy does not go through underwriting before being provided LTD coverage.

As stated in our 12/8/05 letter, we did not deny Ms. Heimeshoff's claim based upon the medical records not supporting her Disability. The reason for the denial was the fact that we were unable to get her attending physician to respond to our letters asking for clarification on her functionality, thus preventing us from determining if she continued to meet the policy definition of Disabled. We still have

not received this clarification. In this case, a formal appeal does not need to be filed to re-open her claim. Our 12/8/05 letter states that we need a response from Dr. Saitta to our 10/21/05 letter asking if she can do sedentary work to re-open her claim. Once we receive it, we will re-open her claim.

If you have any questions, please feel free to contact our office at (800) 492-5678, x64230. Our office hours are 8:00 AM to 8:00 PM EST, Monday through Friday.

Sincerely,

John Wentworth, Senior Examiner
Hartford Life and Accident Insurance Co.

THE HARTFORD

Benefit Management Services
Atlanta Disability Claim Office
P.O. Box 1810
Alpharetta, GA 30023-1810
Facsimile (860) 392-0713

November 29, 2006

Krafchick Law Firm
Attn: Kristian Soholm
2701 First Ave.
#340
Seattle, WA 98121

Policy Holder: Wal-Mart Stores, Inc.
Associate: Julie E. Heimeshoff
Policy Number: GLT024554

Dear Ms. Soholm:

We are writing to you about your client's claim for Long Term Disability (LTD) benefits. These benefits are under the group insurance policy number GLT024554 for Wal-Mart Stores, Inc.

We have completed our review of your client's claim for benefits and have determined that she does not meet the definition of Total Disability throughout and beyond the Elimination Period (06/09/05-09/08/05). Because of this, Long Term Disability (LTD) benefits are not payable to her under the terms of this policy.

On page 14 of the Policy, it states "You will be paid benefits if, while insured under the group policy, you:

(1) become Totally Disabled;

(2) remain Totally Disabled throughout the Elimination Period;

(3) remain Disabled beyond the Elimination Period; and

(4) submit proof of loss satisfactory to The Hartford,"

On page 5 of the Policy, it states "Total Disability or Totally Disabled means that:

(1) during the Elimination Period; and

(2) for the next 12 months, you are prevented by:

(a) accidental bodily injury;

(b) sickness;

(c) Mental Illness;

(d) substance abuse; or

(e) pregnancy,

from performing the essential duties of your occupation, and are under the continuous care of a Physician and as a result you are earning less than 20% of your Pre-disability Earnings, unless engaged in a program of Rehabilitative Employment approved by us.

After that, you must be so prevented from performing the essential duties of any occupation for which you are qualified by education, training or experience.

'Your occupation' includes similar job positions with the Employer which may be offered to you, with a

rate of pay 50% or greater of your Indexed Pre-Disability Earnings."

On page 6 of your policy, it states "Elimination Period means the period of time you must be Totally Disabled before benefits become payable."

On page 4 of your policy it states "Elimination Period: With respect to associates in Classes 1-3, the latter of:

(1) the first 90 days of any one period of Total Disability; or

(2) the end of your Employer sponsored salary continuation program."

We based our decision to deny your claim on policy language. All the papers contained in your client's file were viewed as a whole. This included:

1) A signed LTD application from Ms. Heimeshoff dated 08/22/05.

2) A signed Attending Physician Statement from Dr. Saitta dated 09/23/05.

3) Medical records from Dr. Saitta from 06/09/05-09/23/05.

4) Medical records from the Mayo Clinic from September 2005.

5) Medical records from Dr. Goss from 11/02/04-09/19/06.

6) A Physical Capacity Exam (PCE) by Dr. Becker dated 07/19/06.

7) An independent review of your client's medical records by Dr. Bress, Rheumatologist, from the University Disability Consortium dated 11/20/06.

8) Attempt by Dr. Brees to discuss your client's case with Dr. Saitta on 11/20/06.

9) A Physical Demands Analysis from Wal-Mart for a Senior Public Relations Manager showing her job as sedentary in nature.

We had your client's medical records reviewed by an independent physician, Dr. Bress on 11/20/06 to determine if your client was able to perform the essential duties of her occupation as a Senior Public Relations Manager throughout and beyond the Elimination Period (06/09/05-09/08/05). Dr. Brees attempted to discuss Ms. Heimeshoff's case with Dr. Saitta on 11/20/06 but was informed to put his questions in writing. At this time, Dr. Bress has not received a response from Dr. Saitta. It should be noted, as stated in our 12/08/05 denial letter, that we never received a response from Dr. Saitta for clarification on your client's functionality that was sent to him on 10/21/05, 11/1/05, 11/8/05 and 11/21/05.

After reviewing all of the available records, it is Dr. Bress's medical opinion that Ms. Heimeshoff was able to physically perform the activities of her sedentary occupation since 06/08/05. Exams, including a team of physicians at the Mayo Clinic, have consistently revealed no exam findings except for tender points. There is no objective findings to support continued

medical supervision. In addition there is no support for Dr. Becker's assertion that work rehabilitation is risky because of heart rate elevation. It is stated in her medical records that she does not exercise. Because of her deconditioning, it is not surprising that her heart rate increases with activities. It is Dr. Bress's opinion that the increase in heart rate during the PCE is of no diagnostic relevance.

The Physical demands Analysis completed by Ms. Heimeshoff's employer shows that her job is sedentary in nature. Based upon Dr. Bress's review of your client's records, it is his opinion that your client is physically able to perform the activities of her sedentary occupation with her diagnosis of Fibromyalgia since 06/08/05. Therefore, the current medical does not support that your client lacks the functionality to perform the duties of her own occupation throughout the Elimination Period and no LTD benefits are payable to her.

The Employee Retirement Income Security Act of 1974 (ERISA) gives you the right to appeal our decision and receive a full and fair review. You may appeal our decision even if you do not have new information to send us. You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim. If you do not agree with our denial, in whole or in part, and you wish to appeal our decision, you or your authorized representative must write to us within one hundred eighty (180) days from your receipt of this letter. Your appeal letter should be

signed, dated and clearly state your position. Along with your appeal letter, you may submit written comments, documents, records and other information related to your claim.

Once we receive your appeal, we will again review your entire claim, including any information previously submitted and any additional information received with your appeal. Upon completion of this review, we will advise you of our determination. After your appeal, and if we again deny your claim, you then have the right to bring a civil action under Section 502(a) of ERISA.

Please send your appeal letter to:

Claim Appeal Unit
Benefit Management Services
Hartford Life Insurance Company
P.O. Box 2999
Hartford, CT 06104-2999

If you have any questions, please feel free to contact our office at (800) 492-5678, x64230. Our office hours are 8:00 AM to 8:00 PM EST, Monday through Friday.

Sincerely,

John Wentworth, Senior Examiner
Hartford Life and Accident Insurance Co.

CC: Julie E. Heimeshoff

Krafchick Law Firm

Legal Services for Injured People

2701 First Avenue, Suite 340
Seattle, Washington 98121-1123
(206) 374-7370 Fax (206) 374-7377
Email: klf@krafchick.com

Steven P. Krafchick
Attorney at Law

Kristian E. Soholm
Attorney at Law

Legal Assistants:
Julia Busko
Curtis Williams
Nadia Sayah-Sina

May 24, 2007

John Wentworth
Hartford Life Insurance Company
Benefits Management Services
PO Box 2999
Hartford, CT 06104

RE: Our Client: Julie Heimeshoff
Your Insured: Julie E. Heimeshoff
Claim No.: GLT024554
Date of Loss: 6/7/2005

Dear Mr. Wentworth:

Please take notice that we are appealing your decision to deny our client's claim for Long Term Disability (LTD) benefits as stated in you letter of November 29, 2006, received by our firm on December 4, 2006.

We are currently gathering material to support Ms. Heimeshoff's disability and will need more time to submit information. We request that you provide

until September 30, 2007 to submit additional materials we agree to the tolling of the time you will need to make your decision until the receipt of these supporting documents. This date is requested due to the availability of experts during the coming summer months and that our firm is expected to be moving to a new location in late August or early September.

If we do not hear from you to the contrary within fourteen (14) days, we will consider that as an agreement to this extension request.

Very truly yours,

KRAFCHICK LAW FIRM

/s/ Steven P. Krafchick
Steven P. Krafchick

THE HARTFORD

Mailing Address: P.O. Box 2999
Hartford, CT 06104-2999

June 5, 2007

Steven Krafchick
2701 First Ave.
#340
Seattle, WA 98121

Policy Holder: Wal-Mart Stores, Inc.
Associate: Julie E. Heimeshoff
Policy Number: GLT024554

Dear Mr. Krafchick:

We have received your letter indicating that you are appealing the decision that was made on your client's claim for Long Term Disability (LTD) benefits.

Your letter states that additional information will be submitted in connection with the appeal. Please send that information to the following address:

BMS Claim Appeal Unit
Benefit Management Services
Hartford Life Insurance Company
P.O. Box 2999
Hartford, CT 06104-2999

Please note that we will grant an extension ending on September 30, 2007. If we do not receive additional information by that time, we will evaluate your appeal using the information currently in our file.

Appeal Unit
Benefit Management Services
Hartford Life and Accident Insurance Co

Krafchick Law Firm

Legal Services for Injured People

2701 First Avenue, Suite 340
Seattle, Washington 98121-1123
(206) 374-7370 Fax (206) 374-7377

Steven P. Krafchick
Attorney at Law

Kristian Erik Soholm
Attorney at Law

Julia Busko
Curtis Williams
Nadia Sayah-Sina
Legal Assistants

September 26, 2007

Via Federal Express

Claim Appeal Unit
Hartford Life Insurance Company
7 Waterside Crossing, 2nd Floor
Windsor, CT 06095

Our Client/Your Insured:	Julie E. Heimeshoff
Policy No.:	GLT024554
Policy Holder	Wal-Mart Stores, Inc.

To Whom It May Concern:

* * *

MEDICAL SUPPORT

Sheila Bastien, Ph.D.
Neuropsychologist

Dr. Bastien has an extensive background in evaluating chronic illnesses' effects on neurocognitive functioning, and her credentials are beyond reproach. For an overview of Dr. Bastien's credentials, please

see her abbreviated curriculum vitae at the end of her updated report, attached hereto as Exhibit 2. Ms. Heimeshoff presented to Dr. Bastien for a two-day neurocognitive evaluation on August 29 and 30, 2007. Dr. Bastien reviewed extensive medical records and expert reports, as noted in her report. As Dr. Bastien's report is extensive, please read it carefully for detail, as only excerpts are included here. Dr. Bastien states:

> 1. Julie Heimeshoff is a 39-year old woman who worked at Wal-Mart Inc. for over 20 years. Her last position was as a Senior Public Relations Manager. She developed fibromyalgia symptoms and problems in the early 1990s, which have continued and worsened over time. The medical records show that she was very reluctant to leave her employment but finally conceded. I have reviewed extensive medical records which have documented her chronic pain syndrome, fibromyalgia, irritable bowel syndrome, TMJ, interstitial cystitis, allergies, and recurrent sinusitis.
>
> 2. She currently has uneven intellectual functioning with a Verbal IQ in the very superior range, and Full-Scale IQ just barely in the Superior range. Performance IQ is average. There is a great deal of scatter in her scaled scores suggesting multiple areas of weakness. She was placed in high-potential classes and was evaluated with an IQ test in high school, which she reports was 127, but easily could have been 130. In any case, the high school placed her in advanced classes

based on her IQ test, and that is usually for very superior IQ. Since her verbal IQ is in the very superior range currently, I would not doubt that. She evidenced confusion on arithmetic, and problems with short-term memory and concentration. There was some difficulty with remote memory. Her processing speed was compromised, and tests of perceptual organization were performed somewhat slowly.

3. On the Halstead-Reitan Neuropsychological Battery (HRNB), she had problems in sequencing and shifting sets. Her performance is quite slow, and places her in the moderate to severe range of functioning, indicating a slowed processing speed. This can comprise executive functioning. She had problems on two of the indicators on the tactual performance test. One of the most notable problems on the HRNB were the abnormal motor findings. She is bilaterally impaired on a test of motor speed and persistence. Her left hand is slightly weaker than expected, and she is moderately impaired, bilaterally on a test that measures speed, fine-motor control, and dexterity. I noticed a bilateral fine tremor, worse on her left hand.

4. An additional motor test was given, the Purdue Pegboard Test, where she has very poor scores. In fact, her score on both hands together is so low that it would likely indicate, or at least suggest, an organic/neurologic problem. Fine motor speed and

dexterity are required for most jobs in the national economy; her scores are too low.

5. On auditory verbal memory, her performance is mild to moderate. **After a four hour delay, she has problems remembering a sufficient number of items and scores in the severe range.** Even on figural memory she has problems. On initial figural learning, she is mild to moderately impaired. On delayed, she is moderately impaired. She has some problems in short term memory and some minor problems in remote memory, as well as being below average on incidental memory, and mildly impaired on memory for spatial localization.

6. **On the Thurstone Verbal Fluency Test, her raw score is 43; 45 is the cutoff for brain damage – so her score places her in the brain damage range. This is very unexpected.** This test is compromised when there are frontal lobe problems, particularly the left-frontal lobe. This affect's executive functioning. From the tests it is clear that there are other areas of the brain that are affected as well.

7. **On the Differential Aptitude Test, three of the aptitude/ability areas are too low for her work as a Senior Public Relations Manager.** Numerical ability and abstract reasoning are below what is required, however, the most notable of all is the very low score, in the 10th percentile in Clerical Speed and Accuracy. **This score is so**

low that one could not function in any job requiring paper work or quick processing of numbers and symbols.

8. **There is no evidence of malingering.**

9. No significant depression was noted during my evaluation nor was there any significant anxiety present.

10. A performance-based physical capacity evaluation, signed by Theodore J. Becker, PhD on 07/19/07, gives an opinion that the examinee should be considered work intolerant. His opinion is that physiological response shows that competitive and predictable sustained work is absent for all levels of category, according to the Dictionary of Occupational Titles.

11. **Ms. Heimeshoff, in my opinion, is not able to function in the workplace at this time or the foreseeable future in any area for which she has reasonable training and experience, and this has been so since 06/07/05. In fact, some of her scores are so low that she could not even function at entry-level office work, given her pain and medical problems.**

Stephen Goss, MD
Internist

Dr. Goss has been one of Ms. Heimeshoff's treating physicians since 2002, and is very familiar with her medical chart. He has reviewed all the recent reports

submitted with this letter, and is clear in his opinion that Ms. Heimeshoff is totally disabled and unable to work due to the chronic pain and fatigue she experiences as a result of her fibromyalgia. His report is attached as Exhibit 3. Dr. Goss states:

> This letter is in follow up to a correspondence from myself dated September 19, 2006 regarding Julie Heimeshoff referenced above. This has had to do with Ms. Heimeshoff's long term disability benefits through the Hartford Company. This letter serves to update my previous correspondence including her update medical status as well as incorporating some new evaluations.
>
> **Ms. Heimeshoff has continued to have chronic pain especially in her hips and lower extremities but having variable muscular discomfort at almost all times.** She also is bothered by headaches occasionally that are relatively severe and I think are migraine in nature and continues to have difficulty with organizing her day and her condition. Her pain finally got to the point that we had no choice but to go to some chronic narcotic therapy and she now takes OxyContin and Oxycodone on a regular basis. She has shown no tendency to try to abuse these medications and is on a stable monthly dosing.
>
> Since the last letter was written and before staring her on narcotic therapy she did undergo a psychiatric evaluation with Dr. Stephen Dollins who diagnosed her as a cognitive

disorder not otherwise specified. We also had her see Dr. Cannon, a local pain specialist, who recommended increasing her dose of Lyrica but was supportive of narcotic therapy. Also during this time I have seen where Dr. Theodore Becker gave a strong rebuttal to the Hartford doctor's evaluation of Ms. Heimeshoff. That rebuttal was dated September 04, 2007. In addition, I have reviewed a neuropsychological assessment performed by Dr. Sheila Bastien dated September 13, 2007. Dr. Bastien's assessment fits well with Ms. Heimeshoff's situation again showing a cognitive disorder of a relatively severe degree.

In addition, I believe Ms. Heimeshoff has undergone another evaluation in regards to exercise tolerance. I do not have that report but understand it again revealed significant decreases in tolerance. Again this, as well as the above evaluations, continue to fit with the clinical picture that I see on at least a monthly basis in my clinic. Ms. Heimeshoff continues to struggle with discomfort that is difficult to control, is relatively functional at home but only for brief periods of time, and given some of the cognitive dysfunction that's well outlined in these other reports it would certainly be difficult for her to hold down a job even a sedentary one since she does struggle even at home with maintaining her own household.

Although it would be very natural for Ms. Heimeshoff to be depressed none of her evaluations have ever shown her to be significantly depressed. Depression has even been empirically treated without any significant improvement in her situation in the past.

To recap, I have routinely seen Ms. Heimeshoff since July of 2002. In light of the corroborating assessments that have more recently been done coupled with the previous assessments and my week-to-week, month-to-month clinical impression that is no different than the previous evaluations, I do not think Ms. Heimeshoff is capable of employment even if in a sedentary job. **Since June 8, 2005 she has been unable to work in any occupation on a regular full-time basis with any day-to-day or week-to-week regularity all related to the above findings of fatigue, chronic pain, and cognitive problems related to her fibromyalgia.** I think she is so incapacitated due to muscular discomforts that even if it only required getting up and down on rare occasions and carrying only very light loads of files she could not do it. In addition, I do not think the cognitive dysfunction will allow her to function even if her muscular pain and fibromyalgia was completely controlled as well as her having relatively significant occasional to frequent headaches.

Michael Saitta, MD
Rheumatologist

Dr. Saitta has been Ms. Heimeshoff's primary treating rheumatologist for a number of years. Hartford has on several occasions sought functional capacities evaluations from him, hoping to establish Ms. Heimeshoff's level of physical functionality to see if she is physically unable to work a regular, full-time job. Dr. Saitta declined Hartford's request, noting that he does not feel comfortable with performing a functional evaluation as that is outside his specialty. Therefore, Dr. Saitta has deferred that responsibility to the proper authority on functional capacity, a physical capacities expert, such as Theodore Becker, Ph.D. Please see Dr. Saitta's note attached hereto as Exhibit 4.

Theodore Becker, Ph.D.
Performance Based Physical Capacities Evaluator

Dr. Becker is a preeminent physical capacities evaluator. Hartford was already sent Dr. Becker's first full report on October 2, 2006, but did not seem to pay much attention to his findings. Hartford should carefully read both Dr. Becker's full report and the addendum thereto, Exhibit 5, as it contains valuable information related to Dr. Bress's inability to properly evaluate matters involving physical capacities. Dr. Becker reviewed Dr. Bress's November 20, 2006 report, and states:

In regards to the letter of Dr. Norman M. Bress, M.D., FACP, FACR in which he states the following: "I therefore find no support for Dr. Becker's contention that the insured needs 'continuing medical supervision'. In addition there is no support for Dr. Becker's assertion that work rehabilitation is risky because of heart rate elevation. It is stated in insured's record that she does not exercise. Because of her deconditioning, it is not surprising that her heart rate increases with activities, even minimal exercise. It is therefore my opinion that the increase in her heart rate during the PCE is of no diagnostic relevance".

Dr. Norman Bress comments are the most unprofessional and irrelevant comments I have ever encountered in over 35 years of experience in clinical work and exercise physiology testing. Dr. Bress's professional accreditation is in rheumatology and NOT IN WORK OR EXERCISE PHYSIOLOGY. I have achieved a certification through the American College of Sports Medicine (ACSM) as a provider of exercise testing, and having been applying those principles for over 31 years. **I am published in both textbooks and professional publications on the interpretation of work tolerance.** My most recent publication, 'Applications of Work Physiology Science to Capacity Test Prediction' includes 105 bibliographic citations and was three years in preparation and has been

scientifically peer reviewed. (See my previously provided professional resume).

Furthermore, **I was on faculty at the Southwestern Medical School, University of Health Science Center at Dallas when our research team coined the term 'deconditioning'**, which is short for involuntary biomechanically restricted deconditioning. Dr. Brass has absolutely no idea what he is talking about concerning 'heart rate that increases with activities, even minimal exercise'. In this case we are not talking about 'EXERCISE', the testing refers to work task exposure which simulates actual reauirements of postures and positions. If Dr. Bress knew anything at all about work 'physiological' response he would know that there are exacting expectations about response to work tasks and that 'EVEN MINIMAL EXERCISE does not normally elevate physiological response, and does not cause excessively long recovery to resting responses. Dr. Bress was 'SHOOTING FROM THE HIP', and **provided absolutely no proof of his opinions and provided absolutely no scientific explanation for his opinion.** If his opinion were reviewed by a scientific committee he would be considered to have provided nothing but a 'JUNK SCIENCE OPINION'. According to Bassey, MacDonald and Patrick, 1982, (from the European Journal of Applied Physiology) reported that the individual's physical tolerance to work as reflected heart rate was directly proportional to their physical need for oxygen consumption. This remains a

basic widely accepted principle today. When a worker's condition was tolerant to standard intensity of work, there was a sustainable physiological response, which is measurable by heart rate. However, when the requirement of the work exceeds the tolerance of the individual, the heart rate elevated over time while the work function decreased symbolizing a decrease in oxygen delivery and the onset of physiological fatigue. Furthermore, Davies, 1966, pointed out the main barrier of physician understanding in work physiology was a lack of understanding of the significant difference between exercise and work physiological testing and a failure to appreciate the underlying physiological principles upon which work is based. Clearly, from the statements of Dr. Bress it is understood that he has 'ABSOLUTELY NO UNDERSTANDING OF WORK PHYSIOLOGY', and the ongoing validity of the 1966 observation by Davies.

To state, as Dr. Bress has, that 'heart rate has no diagnostic relevance' is as stupid a statement as any I have ever encountered in my years of practice. The American College of Sports Medicine has a text, Guidelines for Exercise Testing, revised more than seven times, which is detailed in the examination of heart rate as a diagnostic tool regarding pathology, physiological tolerance, and indication regarding exercise rehabilitation. One of the contraindications to stress induced exercise for rehabilitation is an excessively elevated heart rate response with an excessively long

recovery to resting, like that of Ms. Hemishoff. In the presentation of the contra-indicated systemic physiological response the professional approach is to seek medical intervention from a provider with appropriate credentials. **I do not see where any of Dr. Bress credentials are worthy of consideration for interventions related to systemic physiological disorders.** Therefore, Dr. Bress's contention that 'there is no support for work rehabilitation because it is risky business because of heart rate elevation' only goes to indicate how insignificant his knowledge is concerning the relationship of task exposure and work tolerance.

To the readers of his correspondence I would point out that **Dr. Bress provided absolutely no scientific foundation for his opinion, and absolutely no scientific rebuttal to the data in the PCE evaluation, yet he boldly stated, '. . . the PCE is of no diagnostic relevance.** Dr. Bress's opinion is rubbish. My opinions stand on the science of work physiology stretching back to the work of A.V. Hill, 1927, as applied to the PCE report and opinions. This 1927 work remains accepted today as the basis for evaluating human performance and physical capacity testing.

Hartford would be well advised to re-read Dr. Becker's report, as his findings regarding Ms. Heimeshoff's ability to work stand, and remain unrebutted.

Staci R. Stevens, MA
J. Mark VanNess, Ph.D.
Cardiopulmonary Exercise Evaluation

Cardiopulmonary exercise (CPX) evaluation is a close cousin of the typical physical capacities evaluation such as Dr. Becker's, but one where pulmonary and cardiovascular responses to exercise are monitored to eradicate concerns of malingering and to precisely discern the level of cardiopulmonary capacity, and the effects of illness thereon, if any. Ms. Stevens and Dr. VanNess are the principals of Pacific Fatigue Laboratories, and are renowned in the field. Their report and CV are attached hereto as Exhibit 6. CPX is a precise and neutral arbiter of physical dysfunction, as effort and malingering are quickly detected. Ms. Heimeshoff presented for her CPX evaluation on August 27 and 28 of 2007, performing two complete days of testing to evaluate fatigue responses on the second day after the first day's testing. In that manner, fatigue responses to work is evaluated and properly documented.

The evaluators write:

> 1. Assessment of Maximal Effort: The subject was cooperative and gave very good effort during both exercise tests. **The test results do not reflect malingering. Cardiopulmonary exercise testing provides objective measures that cannot be cheated.**
>
> 2. Lung Function: Pre-exercise pulmonary function testing showed no abnormalities, both static and dynamic lung volumes were normal.

The pulmonary response to exercise on test 2 was significantly blunted, especially at maximal workloads. This indicates that prior physical activity will interfere with normal lung function in this particular patient.

3. Metabolic Responses: The peak exercise values for oxygen consumption on test 1 were low reflecting moderate impairment of the metabolic system. **The 16.2% fall in oxygen consumption from test 1 to test 2 demonstrates profound post-exertional impairment of metabolic processes.** This difference is greater than is expected (variability of 8% or less) for other pathological conditions such as heart failure, respiratory disease or cardiac abnormalities. The biggest decrements between test 1 and test 2 were observed at the anaerobic threshold. **Anaerobic threshold is an important index of the amount of work that can be sustained before the body relies more heavily on anaerobic metabolism.** Work intensities above anaerobic threshold require energy production derived from anaerobic sources and limits the duration at which such intensities of effort can be sustained. **Most activities of daily living (reading, normal speed walking, computer use, office-type work, etc.) are aerobic in nature and healthy individuals are able to perform such activities for prolonged periods of time and with no meaningful physical fatigue.** Work at intensities above anaerobic threshold cause cumulative fatigue. If anaerobic threshold occurs at a low work

rate completion of normal daily activities may exceed the energy demands that can be met through oxidative metabolism, thus requiring anaerobic metabolism to provide energy. This results in early onset fatigue. For most individuals, physical demands are considered appropriate if the 8-hour energy expenditure requirement averages less than or equal to 50% of maximal oxygen consumption. **The fall in Ms. Heimeshoff's anaerobic threshold of 36% test 1 to test 2 not only indicates metabolic dysfunction, it indicates dramatic fluctuations in energy availability that make managing difficult within a structured work environment. This is both a demonstration of post-exertional malaise and a quantifiable limitation of her ability to function.**

4. Cardiovascular Responses: The subject demonstrated a normal hemodynamic and ECG response during the transition from rest to exercise, but as exercise intensity increased there was a blunting of the heart rate and blood pressure responses on both exercise tests.

. . .

9. Recovery Response: The reported symptoms indicate atypical and poor recovery. The increase in symptoms and lack of recovery within one day indicate abnormal recovery response.

10. Reproducibility: Cardiopulmonary test-retest variability should be less than 8% for healthy individuals, and even in pathological states such as cardiovascular and pulmonary diseases despite absolute values that may be abnormal, variability should still be less than 8%. In the present report, the inability to reproduce test results for pulmonary or metabolic values on consecutive days indicates a unique pathology and inability to function on subsequent days. This percent decline [illegible] peak oxygen consumption of 16.2%, and the decline in peak ventilation of 18.6% are each greater than expected. Additionally, the large variability in values at the anaerobic threshold, 36% decline for oxygen consumption and 42% in watts, are indicative of the fluctuations in physiological function that make structured work habits difficult to maintain. These findings provide objective evidence of post-exertional malaise and demonstrate metabolic and pulmonary dysfunction.

Summary

The findings indicate diminished functional capacity, inability to sustain work, inability to recover and maintain physical function due to metabolic and pulmonary dysfunction. Any physical work, sustained for more than a few minutes, will elicit a significant fatigue response.

Lay Witness Testimonies

Attached as Exhibit 7 are copies of testimonies by Ms. Heimeshoff's family members and friends. These statements clearly evidence that she is not malingering or otherwise seeking secondary gain.

There are statements by:

- Julie Heimeshoff;
- Volker Heimeshoff, husband;
- Sherli Burns, sister;
- Paula Stimmel, sister;
- Kaylynn Jordan, friend;
- Carla Murray, work friend.

* * *

Hartford Life
Atlanta Disability Claim Office
P. O. Box 1810
Alpharetta, GA 30023-1810

November 26, 2007

Krafchick Law Firm
Kristian Erik Soholm, Attorney at Law
2701 First Ave, Ste 340
Seattle, WA 98121-1123

Policy Holder: Wal-Mart Stores, Inc.
Claimant: Julie E. Heimeshoff
Policy Number: GLT024554

Dear Mr. Soholm:

We have received the appeal that you submitted in connection with the above referenced claim for Long Term Disability (LTD) benefits. Please refer to our letter of 11/29/06 (copy attached) which listed the policy provisions that apply to this matter. That letter also listed the evidence contained in your client's claim file. We have again reviewed those items, along with the following specific information:

- Appeal Letter from you dated 5/24/07 and 9/26/07
- Fibromyalgia Literature
- Neuropsychological Report by Sheila Bastien dated 8/29/07 and 8/30/07
- Medical Letter from Garrett Goss Clinic dated 9/24/07

- Medical Note from Dr. Michael Saiita dated 8/25/07
- Letter from Everett Pacific Industrial Rehabilitation dated 9/4/07
- CPX report from Pacific Fatigue Laboratory dated 8/27/07 and 8/28/07
- Letters from Julie Heimeshoff dated 4/22/07
- Letter from Volker Heimeshoff dated 4/8/07
- Letter from Paula Stimmel undated
- Letter from Sherli Burns dated 8/5/06
- Letter from Kaylynn Jordan dated 4/24/07
- Letter from Carla Murray dated 4/24/07
- Independent Medical Reviews

As part of your appeal you have presented literature, additional medical information and letters from your client, family and friends. Also, you note disagreement with the claim handling, investigation and that your client should have been physically examined by an Independent Medical Professional.

In order to provide a fair and impartial appeal review, the claim file was examined.

The date of disability was 6/9/05 but your completed claim filing was 10/2/06, over a year later, an Independent Medical Examination would not have been a true example of your Client's functionality. A physical examination would not support your client's level of functionality at the time of disability as it had been

over a year between her date of disability and the final claim filing. Therefore, in order to medically clarify her condition and level of functionality as of the 6/9/05 date of disability, your client's file was referred for Independent Medical Reviews by Specialists.

Your client's medical records were reviewed by a Board Certified Rheumatologist. The medical record supports your client retains the residual physical capacity to perform sedentary work, and therefore has the work capacity to perform her occupation. The basis of the impairment supported by the attending physicians is the subjective complaints of pain and fatigue that is reported to affect cognitive function.

The data fails to support severity. The assessment of the PBPCE which was performed by Dr. Theodore Becker, PhD. on 08/10/2006 was reviewed. The elevation in the pulse is consistent with deconditioning; however, it is not of a sufficient severity to preclude your client from performing sedentary work, nor does the elevation in the pulse support that she would fail from a work rehabilitation program. The routine recommendations for the treatment of fibromyalgia include exercise and life style modifications. There is no support in the record that your client would not tolerate, with adequate effort and training, a work hardening program to improve conditioning, and thereby improve work capacity. The residual physical capacity is sufficient for sedentary work occupations.

The effect of pain and the medication used to treat pain requires the recommendations of no working at unprotected heights, no driving a company vehicle, no working with heavy machinery or safety sensitive materials. The recommendations are made to avoid safety risks to the claimant or others as a result of potential decreased cognitive function from the pain or the pain medications.

Your client, based on the medical record, would be independent, ambulating without assistive devices and retains the ability to sit, stand and walk, listen and talk. There are no restrictions on fine motor manipulation or computer entry work. She has subjective complaints of pain and fatigue; the symptoms were reportedly present since 1991, as per the outpatient note with Dr. Shayan Alam on 9/15/05. It is unclear whether the change in 6/05 that resulted in an inability to work was the same pain that dated to 1991 while she was working for 14 years (with pain).

Your client's medical records were also reviewed by a Board Certified Clinical Neuropsychologist. The records indicate she was reportedly diagnosed with Lupus in 1991 and with Fibromyalgia in 1994. The diagnosis of Lupus was doubted on comprehensive evaluation in 2005, with no evidence of the disease at that time. Ms. Heimeshoff apparently complained of a number of somatic problems including pain (multiple types), fatigue, problems with stamina, sleep, as well as difficulties with concentration and memory.

The notes suggested depression with psychopharmacologic treatment that was felt to have had little influence on her status. Ms. Heimeshoff reportedly enjoyed her job and attempted to maintain work activities with the help of her family, friends, and understanding coworkers but stopped working in 6/05. Developmental history was reported to be unremarkable with a mention of childhood speech problems, yet no note of subsequent sequelae and high school GPA = 3.87. The claimant's IQ was measured in 1973 and was reported to be 127 (unverified report, unspecified testing method).

In addition to problems noted above, the medical history was reportedly significant for asthma, gynecological problems with a hysterectomy, osteoporosis, pericarditis, gastrointestinal problems, temporomandibular joint dysfunction, and migraine headaches. Brain imaging was reported to be within normal limits.

Your client's mental health history was noted to be significant for marriage counseling during Ms. Heimshoff's first marriage. There have reportedly been several trials of treatment with antidepressant medications, with no apparent concomitant psychiatric or psychotherapeutic follow-up. There was a reported psychiatric evaluation as a part of Ms. Heimshoff's Mayo Clinic work-up in 2005 with reported indications of depression and anxiety symptoms and suggestions for pharmacotherapy and counseling/psychotherapy. There was no indication of ongoing psychiatric or psychotherapeutic follow-up.

Ms. Heimeshoff is reportedly being treated with long acting opioid analgesics as well as hypnotic medications. A neuropsychological assessment was stated to have been conducted on 9/13/07. Some of the test scores were included in the report. Some cognitive symptom validity testing was done and reported to suggest adequate effort. Assessment of affect was limited to BDI-II which generated a score within the mildly depressed range, though it was interpreted as indicating "minimal depression". The examination of the report and test results suggested largely normal cognitive performance, with some weak and inconsistent scores. Performance on measures assessing speed of information processing was inconsistent with some of the simpler measures generating low scores, while more complex ones producing normal levels of performance. While measures of manual motor speed and dexterity were in the mildly to moderately impaired range, Ms. Heimeshoff still demonstrated entirely normal performance with both hands on a complex task requiring efficient integration of spatial and motor functioning. Her attention and immediate memory performance was well within normal limits. Memory performance was weak, although the assessment was quite limited, based on one verbal and one non-verbal measure. Influence of emotional/ personality status on current presentation was not sufficiently assessed. Symptom validity with regard to endorsement of complaints of somatic or emotional difficulties was not assessed.

Information relevant to the field of neuropsychology did not support the presence of notable restrictions or limitations. Results of the neuropsychological assessment generated largely normal findings with some variable and low scores.

The available data relevant to the field of neuropsychology do not indicate restrictions or limitations. The presence of problems is based on Ms. Heimshoff's subjective complaints. The neuropsychological assessment offered limited evaluation of cognitive and emotional functioning that does not rule out the influence of emotional factors such as possible somatoform disorder, or motivation for secondary gain. It may be noted that the presence of somatoform disorder does not rule out successful engagement in work activities. Ms. Heimeshoff is apparently being maintained on several medications including opiate analgesics and hypnotics. These medications would require restrictions from working with heavy machinery, driving a company vehicle, and no working at heights.

The neuropsychological evaluation results suggested a largely normal level of functioning with some variable and weak scores. Some areas of functioning were insufficiently addressed. Most importantly, assessment of "affective status" was based on a single brief inventory assessing depression and not containing any validity indicators. Affective and somatoform factors are likely influences in this case and necessitate comprehensive testing (e.g., MMPI-2). Assessment of learning and memory was quite limited with one measure in the verbal and one in the nonverbal

domain. Some additional learning and memory-related information can be gained from other data, yet overall this testing seems insufficient.

There was some concern regarding test administration and scoring. "Word Memory Test" was not listed among the administered tests, yet was included among the test results with a reported "perfect score". If the examiner referred to the Green's Word Memory Test, it contains several indices and it is unclear which indicator was reported or which portions of this measure were administered.

With regard to interpretation, the examining neuropsychologist seems to have overemphasized some of the findings to suggest pathology without sufficient justification. For example, despite a very good, high average level score on the information subtest, a measure of fund of general knowledge, performance was felt to indicate cognitive slippage, some loss of remote memory, and confusion. The source of this interpretation was not clear. An error on the most difficult and commonly missed item of the Arithmetic subtest indicated "a problem with dyscalculia" despite a clearly normal overall score that was within the upper portion of the average range. "Organic-like reversals" were reported for the Digit Span subtest despite a normal level score, and common occurrence of reversal errors regardless of cerebral dysfunction. On the Tactual Performance Test, the three timed block placement trials were performed well within normal limits relative to Heaton (2004) age and education-stratified norms. In the report this performance was

felt to suggest "tactual-perceptual problem with her left hand, or some difficulties in learning". In fact, this performance suggests good manual dexterity and speed of processing and normal procedural learning over trials. One mildly impaired score on the Thurstone Verbal Fluency Test was felt to suggest "brain dysfunction/damage", despite good performance on several other measures sensitive to cerebral impairment. These limitations as well as some others place doubt on the examining neuropsychologist's conclusions.

Based on the Independent Medical Reviews by Specialists the medical evidence does not support the limitation that your client is unable to perform any level of work/no work capabilities. From review of the additional information provided on appeal along with review of the information previously in file, there is no medical or vocational evidence to refute our original decision. Therefore, the appeal review concludes that the weight of the medical and vocational evidence in our file supports that your client is able to perform at least sedentary full time work and her own occupation is identified within that capacity. Because she is employable in her own sedentary work, she is not disabled and the decision to deny LTD benefits was correct under the terms of the policy. This is our final decision and the file remains closed.

You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your

client's claim. You may bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 ("ERISA").

Sincerely,

/s/ Robyn J. Cote
Robyn J. Cote, Appeal Specialist
Hartford Life and Accident Insurance Co.

Enclosure

UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

JULIE HEIMESHOFF, Plaintiff vs. HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY, a Connecticut Corporation, and WAL-MART STORES, INC., an Arkansas Corporation and plan sponsor of the Group Long Term Disability Plan For Employees of WAL-MART STORES, INC., Defendants.	Civil Action No.: COMPLAINT FOR LONG-TERM DISABILITY BENEFITS NOVEMBER 18, 2010

The Plaintiff, Julie Heimeshoff ("Plaintiff or "Ms. Heimeshoff"), by and through her attorneys Carey & Associates, P.C. and Krafchick Law Firm, PLLC, based on information and belief, alleges as follows:

I. PARTIES, JURISDICTION, AND VENUE

1. Ms. Heimeshoff is an individual adult who is a citizen of the State of Arkansas, County of Benton.

2. Defendant Hartford Life and Accident Insurance Company ("Hartford") is a corporation with its principal place of business in Simsbury, Connecticut.

3. Defendant Wal-Mart Stores, Inc. ("Wal-Mart") is a corporation with its principal place of business in Bentonville, Arkansas.

4. Defendant Wal-Mart Stores, Inc. offered its employees long-term disability ("LTD") insurance through the purchase of a policy of group disability insurance.

5. At all times relevant to this lawsuit, the Group Long Term Disability Plan For Employees of WAL-MART STORES, INC., (hereinafter "Plan" or "the Plan") was funded by a policy of group disability insurance issued by Hartford, bearing policy no. GLT-205215 and policy no. GLT-024554 (hereinafter "Policies" or "the Policies").[1]

6. Hartford administered participants' claims for benefits under the Plan, including the claim for long-term disability benefits Ms. Heimeshoff submitted.

7. The matter in controversy exceeds, exclusive of interest and costs, $75,000.00.

8. Jurisdiction is proper in the United States District Court for the District of Connecticut pursuant to 28 U.S.C. § 1332.

9. Venue is proper in the United States District Court for the District of Connecticut pursuant to 28 U.S.C. § 1391(a).

10. This claim is governed by ERISA 29 U.S.C. § 1001, *et seq.*

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[1] Ms. Heimeshoff incorporates the entirety of the claim file Hartford produced in connection with her claim for long-term disability benefits as if annexed hereto. (Bates nos. CF 00000002-CF00000930).

FACTUAL ALLEGATIONS

11. Ms. Heimeshoff worked for Wal-Mart Stores, Inc. since April 29, 1986. Her last position held was as a Senior Public Relations Manager.[2]

12. While Ms. Heimeshoff worked for Wal-Mart Stores, Inc. she became eligible for LTD insurance.[3]

13. In January 2005, Ms. Heimeshoff was suffering from symptoms of pain and fatigue due to Fibromyalgia.[4]

14. In May 2005 Ms. Heimeshoff's pain, fatigue, and other disabling symptoms increased and the record shows diagnoses of Fibromyalgia with chronic pain, likely Irritable Bowel Syndrome and possible Restless Leg Syndrome, Allergies, and strong past history of lupus.[5]

15. Ms. Heimeshoff tried to continue working despite her medical conditions. However, due to her significant pain, extreme fatigue, and cognitive impairment, she had to stop working on or about June 8, 2005.[6]

16. Ms. Heimeshoff has been unable to sustain full-time employment since approximately June 6,

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[2] CF 00000082

[3] CF 00000082

[4] CF 00000859

[5] CF 00000855

[6] CF 00000082

2005, due to severe Fibromyalgia and other disabling conditions.

17. The Social Security Administration has deemed Ms. Heimeshoff disabled since June 6, 2005.

18. Hartford defines Disability as follow:

> **Total Disability or Totally Disabled** means You are prevented from performing the Essential Duties of:
> 1) Your Occupation or a Reasonable Alternative Job offered to You by the Employer during the Elimination Period and for the 12 months following the Elimination Period, and as a result Your Current Monthly Earnings are less than 20% of Your Pre-disability Earnings; and.
> 2) after that, Any Occupation.[7]

19. Ms. Heimeshoff has been unable to perform the essential duties of her own occupation or any occupation, for profit, since June 6, 2005.

20. As a result of her multiple medical conditions causing generalized pain and fatigue, Ms. Heimeshoff meets the definition of "total disability" contained in Hartford's Policy.

21. By letter dated August 19, 2005, Hartford sent Ms. Heimeshoff a letter stating the following:

> **Our records indicate that your disability may extend beyond the 90 day Salary Continuation period.** In order to

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[7] CF 00000008

> determine your eligibility for Long Term Disability (LTD) benefits, please complete and return the enclosed Group Claim forms.[8]
>
> (emphasis added).

22. Ms. Heimeshoff filed a claim for LTD benefits with Hartford, listing extreme fatigue, significant pain, and difficulty in concentration, on or August 22, 2005.[9]

23. Ms. Heimeshoff's claim for long-term disability benefits was supported by an Attending Physician Statement completed by her rheumatologist, Michael Saitta, M.D., with a diagnosis of SLE (Systemic Lupus Erythematosis) and Fibromyalgia, with symptoms of pain and fatigue, and findings of tender points dated September 23, 2005.[10]

24. Ms. Heimeshoff underwent a thorough workup at the Mayo Clinic in September 2005 where she was evaluated for daily headaches, Fibromyalgia, depression, chronic sinusitis, ERT, back pain and alternating bowel pattern.[11]

25. The Mayo Clinic physicians diagnosed Ms. Heimeshoff with Irritable Bowel Syndrome (IBS), chronic pain syndrome consistent with Fibromyalgia, chronically positive ANA with no definite history of Lupus, Fibromyalgia, Allergic rhinitis,

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[8] CF 00000927

[9] CF 00000917-919

[10] CF 00000923-924

[11] CF 00000814-815

Asthma, sleep disorder secondary to chronic persistent pain and chronic migraine headaches.[12]

26. By letter dated November 29, 2005, Hartford notified Ms. Heimeshoff that they have not received a response from Dr. Saitta regarding clarification on her functionality and that they cannot make a claim determination.[13]

27. That November 29, 2005 letter states the following:

> We cannot make a claim decision without this information because it is needed to determine if you meet the policy definition of Disabled. This delay is for matters beyond our control. **If we get the information requested, we expect to make our decision within 30 days after receiving the information or advise you of the need to further extend the decision period.**[14]
>
> (emphasis added).

28. By letter dated December 8, 2005, Hartford denied Ms. Heimeshoff's claim for disability benefits:

> We are writing to you about your claim for Long Term Disability (LTD) benefits. These benefits are under the group insurance

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[12] CF 00000819, 820, 823, 827, 833, 847

[13] CF 00000073

[14] CF 00000073

policy number GLT024554 for Wal-Mart Stores, Inc.

We have completed our review of your claim for benefits and have determined that you have failed to provide satisfactory Proof of Loss to The Hartford. Therefore, we have determined that you are not eligible for LTD benefits at this time.

. . .

The following information, not previously submitted, is necessary for a determination of your claim. Specifically, **a response from Dr. Saitta to our letter requesting clarification on your functionality. This information is necessary in order for The Hartford to assess your claim and determine if you meet the definition of Totally Disabled from your own occupation at Wal-Mart Stores, Inc.** If you would like this information considered, we must receive it as soon as possible. Please send it to the claim office at the address shown on this letterhead.[15]

(emphasis added).

29. Ms. Heimeshoff obtained counsel in May 2006 in order to assist her in acquiring the "satisfactory Proof of Loss" the Hartford was requesting.[16]

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[15] CF 00000069-72

[16] CF 00000068

30. By letter dated May 31, 2006, Hartford confirmed that no formal appeal was necessary and that if Hartford received clarification of Ms. Heimeshoff's functionality, they would re-open the claim.[17]

31. In order to provide Hartford the requested functional capacity clarification, Ms. Heimeshoff underwent a two-day Performance-Based Physical Capacity Evaluation ("PCE") on July 18 and 19, 2006.[18]

32. After undergoing a battery of performance tests, Dr. Becker concluded the following:

> **Functional Application**
> The deficits identified in the objective testing and physiological screening shows application barriers which will negatively effect vocational options, avocational interests, and options undertaken in quality of life functions.
>
> . . .
>
> **Work Tolerance**
> The physiological profiles show that the examinee should be considered work intolerant. The physiological response shows that competitive and predictable sustained work is absent for all levels of category

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[17] CF 00000068

[18] CF 00000638

according to the Dictionary of Occupational Titles.[19]

33. Dr. Saitta, Ms. Heimeshoff's rheumatologist, explained his non-response to Hartford's request for a filled out detailed physical capacity form by letter dated August 25, 006, stating "any such assessment should be made by an experienced physical capacity expert."[20]

34. By letter dated September 19, 2006, Ms. Heimeshoff's primary treating physician since July 2002, Stephen L. Goss, M.D., confirmed that Ms. Heimeshoff is totally disabled and has been unable to work since June 2005.

35. On October 2, 2006, Ms. Heimeshoff's counsel forwarded Dr. Becker's PCE to the Hartford along with the report from Ms. Heimeshoff's primary treating physician, Dr. Stephen Goss.[21]

36. Hartford hired University Disability Consortium (UDC) requesting that a **Rheumatology Specialist** give his opinion of Ms. Heimeshoff's functional capabilities 6/8/05.[22]

37. Rheumatology Consultant Norman M. Bress, M.D. reviewed Ms. Heimeshoff's medical records. Dr. Bress spent 8.8 hours and charged $2,092.50 for performing the following activities: Organize, **review records including a very**

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[19] CF 00000665

[20] CF 00000538

[21] CF 00000635-636

[22] CF 00000623

lengthy detailed PCE of 27 pages – some notes hand written and very difficult to read (5.7 hours); Call to the office of Dr. Saitta – spoke with staff (.3 hours); Type and edit report (2.8).[23]

38. Dr. Bress' report dated November 20, 2006, ignores and discounts Dr. Goss' report and the detailed PCE of 27 pages providing evidence of work intolerance based on objective test results. Dr. Bress states the following:

> Exams, including those of a team of physicians at the Mayo Clinic, have consistently revealed no significant findings except for tender points. I therefore find no support for Dr. Becker's contention that the insured needs "continuing medical supervision." In addition there is no support for Dr. Becker's assertion that work rehabilitation is risky because of heart rate elevation. It is stated in insured's record that she does not exercise. Because of her deconditioning, it is not surprising that her heart rate increases with activities, even minimal exercise. It is therefore my opinion that the increase in her heart rate during the PCE is of no diagnostic relevance.
>
> With regard to functionality in patients with FM, clinical studies published in the medical literature (see references below) reveal that the majority of patients with

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[23] CF 00000587-588

FM are working full time in their usual occupation. . . .

. . .

Answers to specific questions:

I. It is my opinion that the insured was able to perform the activities of her sedentary occupation since 06/08/2005 through the present, on a physical basis. This is my opinion whether or not she fits the 1990 ACR criteria for the diagnosis of FM. Please refer to above narrative for the basis for my opinion.

2. It is my opinion that the insured is currently able to work full time in a sedentary capacity, on a physical basis. She has been capable of this level of work throughout the time encompassed by the records provided to me. Please refer to above narrative for the basis for my opinion.

3. See # 1 and #2 above. Prognosis is good from a physical point of view. Rheumatologist Dr. Warren Blackburn states that "there is no evidence that fibromyalgia is a crippling or incapacitating disorder or is a prodrome for more serious illness."[24]

39. Based on Dr. Bress' medical record review, Hartford ignored the objective evidence of a two-day

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[24] CF 00000582-583

PCE and the opinion of a long-time treating physician report and denied Ms. Heimeshoff's claim by letter dated November 29, 2006, stating that:

> After reviewing all of the available records, it is Dr. Bress's medical opinion that Ms. Heimeshoff was able to physically perform the activities of her sedentary occupation since 06/08/05. Exams, including a team of physicians at the Mayo Clinic, have consistently revealed no exam findings except for tender points. There is no objective findings to support continued medical supervision. In addition there is no support for Dr. Becker's assertion that work rehabilitation is risky because of heart rate elevation. It is stated in her medical records that she does not exercise. Because of her deconditioning, it is not surprising that her heart rate increases with activities. It is Dr. Bress's opinion that the increase in heart rate during the PCE is of no diagnostic relevance.
>
> The Physical demands Analysis completed by Ms. Heimeshoffs employer shows that her job is sedentary in nature. Based upon Dr. Bress's review of your client's records, it is his opinion that your client is physically able to perform the activities of her sedentary occupation with her diagnosis of Fibromyalgia since 06/08/05. Therefore, the current medical does not support that your client lacks the functionality to perform the duties of her own occupation

> throughout the Elimination Period and no LTD benefits are payable to her.[25]

40. Pacific Fatigue Laboratory conducted a two-day functional capacity test called a Cardiopulmonary Exercise (CPX) Evaluation on August 27 and 28, 2007. Based on objective test results, that report states:

> The findings indicate diminished functional capacity, inability to sustain work, inability to recover and maintain physical function due to metabolic and pulmonary dysfunction. Any physical work, sustained for more than a few minutes, will elicit a significant fatigue response.[26]

41. Sheila Bastien, Ph.D., a Neuropsychologist, performed a complete neuropsychological evaluation of Ms. Heimeshoff on August 29 and 30, 2007. Based upon her detailed evaluation, Dr. Bastien found significant neurocognitive deficits that seriously compromised Ms. Heimeshoff' ability to work:

> Ms. Heimeshoff, in my opinion, is not able to function in the workplace at this time or the foreseeable future in any area for which she has reasonable training and experience, and this has been so since 06/07/05. In fact, some of her scores are so low that she could not even function at

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[25] CF 00000061-63

[26] CF 00000546

entry-level office work, given her pain and medical problems[27]

42. By correspondence dated September 4, 2007, Dr. Ted Becker criticized Dr. Bress' report, upon which Hartford relied, in part, as follows:

> To the readers of his correspondence I would point out that Dr. Bress provided absolutely no scientific foundation for his opinion, and absolutely no scientific rebuttal to the data in the PCE evaluation, yet he boldly stated, '. . . . the PCE is of no diagnostic relevance. Dr. Bress opinion is rubbish. My opinions stand on the science of work physiology stretching back to the work of A.V. Hill, 1927, as applied to the PCE report and opinions. This 1927 work remains accepted today as the basis for evaluating human performance and physical capacity testing.[28]

43. On September 24, 2007, Dr. Goss confirmed that Ms. Heimeshoff is totally disabled and has been unable to work since June 2005:

> To recap, I have routinely seen Ms. Heimeshoff since July of 2002. In light of the corroborating assessments that have more recently been done coupled with the previous assessments and my week-to-week, month-to-month clinical impression that is no different than the previous

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[27] CF 00000519

[28] CF 00000540-541

> evaluations, I do not think Ms. Heimeshoff is capable of employment even if in a sedentary job. Since June 08, 2005 she has been unable to work in any occupation on a regular full-time basis with any day-to-day or week-to-week regularity all related to the above findings of fatigue, chronic pain, and cognitive problems related to her fibromyalgia. I think she is so incapacitated due to muscular discomforts that even if only required getting up and down on rare occasions and carrying only very light loads of files she could not do it. In addition, I do not think the cognitive dysfunction will allow her to function even if her muscular pain and fibromyalgia was completely controlled as well as her having relatively significant occasional to frequent headaches.[29]

44. On September 26, 2007, Ms. Heimeshoff appealed Hartford's denial. The appeal contained the most recent reports and conclusions of Dr. Becker (Everett Pacific Industrial PCE), Dr. VanNess (Pacific Fatigue Laboratory (PCE), Dr. Bastien (neuropsychological evaluation), Dr. Goss and Dr. Saitta.[30]

45. Hartford retained RRS (Reliable RS) who selected rheumatologist Tanya Lumpkins, M.D. to review records. In her report dated November 19, 2007, Dr. Lumpkins erroneously concluded, "[t]he

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[29] CF 00000536

[30] CF 00000111-135

objective data fails to support severity." She failed to address the objective evaluation by Dr. Becker. Dr. Lumpkins went on to state:

> "[t]here is no support in the record that the claimant would not tolerate, with adequate effort and training, a work hardening program to improve conditioning, and thereby improve work capacity.[31]

46. Dr. Alexander Chervinsky, Ph.D. also reviewed Ms. Heimeshoff medical records for Hartford through RRS. Dr. Chervinsky concluded that:

> Influences of medication, emotional problems, or motivation for secondary gain may account for the findings, and can not be excluded on the basis of available information.[32]

47. On November 26, 2007, Hartford issued its last and final denial letter.[33]

48. Hartford disregarded the objective and subjective medical evidence that established Ms. Heimeshoff's total disability and entitlement to long-term disability benefits

49. Hartford used biased doctors to review and ignore medical evidence that supported Ms. Heimeshoff's total disability.

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[31] CF 00000095-96

[32] CF 00000098

[33] CF00000083-87

50. Ms. Heimeshoff meets the definitions of total disability contained in the policy and is entitled to receive long-term disability benefits.

FIRST CAUSE OF ACTION
Recovery Of Employee Benefits
(29 U.S.C. 1132(a)(1)(B))

51. Ms. Heimeshoff repeats the allegations contained in paragraphs 1 through 50 as if set forth at length herein.

52. Ms. Heimeshoff's medical condition qualifies her to receive total disability benefits under the policy issued by Defendants' to cover employees, including Ms. Heimeshoff

53. Defendants failed to provide Ms. Heimeshoff a full and fair review of its adverse LTD benefit determination as guaranteed to Ms. Heimeshoff under the terms of the Plan and applicable law.

54. Defendants breached its contractual obligations, including the contractual obligation of good faith and fair dealing with Plaintiff; by denying disability benefits under its policy.

55. 29 U.S.C. 1133, ERISA §503, requires:

> In accordance with regulations of the secretary, every employee benefit plan **shall**
>
> (1) provide adequate notice in writing to any participant . . . whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in manner calculated to be understood by the participant, and

> (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a **full and fair review** by the appropriate named fiduciary of the decision denying the claim.

29 U.S.C. 1133 (2005) (emphasis added); See also 29 CFR 2560.503-1.

56. 29 C.F.R. 2560-503.1(g)(1)(iii) (2005) states: "A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary."

57. ERISA regulations require a meaningful dialogue between claims administrator and beneficiary. In particular ERISA requires defendants to provide Ms. Heimeshoff a description of any additional material or information that was necessary for her to perfect the claim and to do so in a manner calculated to be understood by the claimant pursuant to 29 CFR 2560.503-1(g). Failure to follow the requirements of procedural regulations can result in a finding of abuse of discretion. Defendants failed to meet these requirements and therefore abused their discretion.

58. Defendants, without any reasonable basis, ignored treating physician and expert reports and opinions as to the physical nature of Plaintiffs disability, and cherry-picked the file only for facts and opinions supporting their decision.

59. Defendants failed to notify Ms. Heimeshoff of her rights under ERISA by failing to disclose to her what additional information she should submit in

order to remain eligible for LTD benefits pursuant to 29 CFR 2560.503-1.

60. Defendants failed to have a meaningful dialogue with Ms. Heimeshoff in a manner calculated to be understood by her as required by ERISA.

61. Defendants' actions in administering Ms. Heimeshoff's claim and in denying LTD benefits were arbitrary and capricious.

62. Defendants failed to honor the terms of the Plan.

SECOND CAUSE OF ACTION
Breach of Fiduciary Duty
(29 U.S.C. 1132(a)(2))

63. Ms. Heimeshoff repeats the allegations contained in paragraphs 1 through 62 as if set forth at length herein.

64. At all material times, Defendants were fiduciaries with respect to their exercise of authority over the management of the Plan, their disposition of Plan assets, and their administration of the Plan.

65. Ms. Heimeshoff asserts a claim of breach of fiduciary duty against Hartford and on behalf of, and for the benefit of, the Plan and all its participants

66. Defendants were obliged to discharge their duties as Plan administrators for the exclusive benefit of Plan beneficiaries and participants by paying beneficiaries and participants the benefits to which they were, and are, entitled.

67. At all material times herein, Hartford violated its duties as set forth above, and also by having done the following:

(a) Consciously and unreasonably failing to investigate or evaluate Ms. Heimeshoff's claim fairly or in good faith, instead utilizing the information available to them in a manner calculated to produce a wrongful but plausible sounding justification for denying benefits;

(b) Encouraging the improper termination or denial of a legitimate claim through the use of claims procedures and guidelines designed to increase the level and amount of terminations; and

(c) Failing to consult with qualified medical consultants.

68. Upon information and belief, the medical consultants used by Defendants to deny and limit Plaintiff's claim receive significant income from defendants and/or other insurers for performing medical records reviews and other incidental services, and are biased due to significant financial incentives to render opinions favorable to Defendant.

69. Upon information and belief, Defendant has a long history of employing these medical consultants to render medical opinions about Defendant claimants as it knows their opinions more likely than not will favor Defendant.

70. Upon information and belief, Defendant's alleged record of using these medical consultants to deny claims evidences that it knows they are likely to

opine that claimants can work, meaning Defendant therefore can deny or terminate claims under color of independent medical opinion, when the opinions are neither independent nor derived from proper physical medical examinations.

71. Defendant breached its fiduciary duties toward Plaintiff by hiring record reviewers who ignored two separate functional capacity evaluations, and opine that there are no impairments, contrary to said reports, and outside their own field of expertise.

72. Such denials, under color of independent medical opinion, may cause some claimants to simply accept Defendant's LTD claims denials or terminations and stop pursuing their appeals, to Defendant's financial benefit.

73. If the medical consultants routinely opined that claimants were totally disabled, thereby undermining Defendant's financially driven desire to reduce the outflow of LTD payments, Defendant would likely cease using them for medical records reviews.

74. Defendants habitually violated their fiduciary duties by failing to act in accordance with the Plan documents, failing to use all prudent skill, failing to honor the duty of loyalty to act solely for the benefit of the Plan participants and beneficiaries, and failing to properly evaluate claims for benefits, including Ms. Heimeshoff's claim.

75. As remedies for Defendants' improper actions, Ms. Heimeshoff requests Hartford be removed as

Plan fiduciary; and that all other available and proper relief be awarded.

THIRD CAUSE OF ACTION
Equitable Relief
(29 U.S.C. §1132(a)(3))

76. Ms. Heimeshoff repeats the allegations contained in paragraphs 1 through 75 as if set forth at length herein.

77. Ms. Heimeshoff asserts that a claim for LTD benefits due under the Plan, without more, does not provide an adequate remedy at law in light of Defendants' continuing course of conduct in violation of the terms of the Plan and applicable law.

78. Accordingly, Ms. Heimeshoff seeks equitable relief under 29 U.S.C. §1132(a)(3) against Defendants as an individual Plan participant, on behalf of all other Plan participants, and for the benefit of the Plan itself.

79. Ms. Heimeshoff requests the removal of Hartford as Plan fiduciary as set forth above.

80. In addition, Ms. Heimeshoff seeks an order from this Court requiring that her past and future LTD benefits be paid starting from June 7, 2005, that Defendants be enjoined from terminating LTD benefits for the duration of the applicable maximum benefit period under the Plan, and that she be placed in the same position she would have been in had she timely been paid the LTD benefits to which she was and is entitled ("make-whole" relief), including recovery of interest, attorneys' fees, costs and other losses resulting from Defendants' breach.

THEREFORE, Ms. Heimeshoff seeks the following relief:

81. For a determination that Ms. Heimeshoff is entitled to receive LTD benefits under the Plan, and for an injunction mandating the payment of past and future LTD benefits to Ms. Heimeshoff from June 7, 2005 forward, covering the applicable maximum benefit period under the Plan;

82. For an order, as an equitable remedy, enjoining Defendants from asserting any other income offsets against the LTD benefit;

83. For damages according to proof, including "make-whole" relief as described above;

84. For the Court to find that Hartford abused its discretion, requiring the Court under _to reopen the claim and take further evidence of Ms. Heimeshoff's disability. For a penalty assessed against Hartford for $110 per day per document missing from the file, and identified as this litigation progresses, in accordance with 29 U.S.C. § 1132(c);

85. For attorneys' fees and costs as permitted by law;

86. For interest as permitted by law;

87. For injunctive and equitable relief as set forth above, and

88. For such other relief as the Court deems appropriate, and the evidence supports.

89. **JURY TRIAL DEMANDED:** Ms. Heimeshoff respectfully requests a jury trial on all questions of fact raised by her Complaint.

Dated:
November 18, 2010

PLAINTIFF,
JULIE HEIMESHOFF

By: /s/ Mark P. Carey

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PETITIONER'S BRIEF

RECORD
AND
BRIEFS

No. 12-729

Supreme Court, U.S.
FILED
JUN 25 2013
CLERK

IN THE

Supreme Court of the United States

JULIE HEIMESHOFF,

Petitioner,

v.

HARTFORD LIFE & ACCIDENT INSURANCE CO. AND WAL-MART STORES, INC.,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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QUESTION PRESENTED

Whether a beneficiary's claim for wrongful denial of benefits under § 502(a)(1)(B) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1132(a)(1)(B), accrues for limitations purposes before the beneficiary has exhausted the mandatory, pre-suit, internal review process, thereby permitting a plan to start the clock ticking on a beneficiary's civil claim before the plan has denied the application for benefits and before the beneficiary can file in court.

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INTRODUCTION

The federal courts of appeals have uniformly held that a beneficiary who seeks benefits through her employer-established ERISA plan must exhaust her plan's internal benefits resolution process before filing a federal lawsuit under ERISA's civil enforcement provisions. This mandatory pre-suit exhaustion requirement serves several important purposes: It encourages the private and nonadversarial resolution of the millions of benefits claims filed annually under ERISA, substantially reducing the burden on federal courts; promotes the consistent treatment of claims for benefits by a plan; and creates a clear record for review if resort to federal court ultimately occurs.

Consistent with the exhaustion requirement and long-standing accrual rules established by this Court, the lower courts have also held that a civil claim under § 502(a)(1)(B) alleging the wrongful denial of benefits cannot be filed—indeed, does not come into existence—until the benefits sought have actually finally been denied. In this regard, ERISA is no different from many other federal statutory regimes that couple a mandatory pre-suit process with a right to challenge the outcome of that process in court. In myriad contexts, it is the settled rule that a federal claim does not accrue for limitations purposes until that claim can be filed in court, or, in other words, until the mandatory pre-suit process has been exhausted.

The Second Circuit rejected this core feature of the law when it held that ERISA plans can start the limitations clock running on a beneficiary's federal claim challenging a wrongful denial of benefits under

§ 502(a)(1)(B) *before* the mandatory internal benefits resolution process is exhausted and the request for benefits has been denied—that is, before the beneficiary ever suffers a legal wrong.

In this case, Petitioner Julie Heimeshoff, a permanently disabled former employee of Wal-Mart Stores, Inc., sought to challenge her ERISA Plan's denial of her claim for long-term disability benefits in court. But her plan, provided by Wal-Mart and issued and administered by Hartford Life & Accident Insurance Company (collectively, Respondents) contained a set of provisions that did three things. First, it specified a three-year statute of limitations for any claim brought by a beneficiary against the Plan. Second, it started the clock ticking on this limitations period near the *start* of the mandatory internal claims process—when proof of loss was required to be furnished to the Plan. Third, it kept the clock ticking while the mandatory internal resolution process was ongoing. Under the plan, therefore, Ms. Heimeshoff's limitations clock began running years before her federal claim existed.

This approach is not only incompatible with the text, structure, and purposes of ERISA, but it violates long-settled accrual rules established by this Court. A limitations period on a federal statutory claim cannot start running before the wrongful act giving rise to the injury has ever occurred. Under Respondents' approach, the limitations clock not only starts ticking before injury, but it can completely run out.

Moreover, it is unclear why anyone would want the rule Respondents have advanced. Starting the clock ticking on a § 502(a)(1)(B) denial-of-benefits

claim before the mandatory internal resolution process is completed and keeping it running even while that process is ongoing creates perverse incentives across the board. It discourages good-faith pursuit and administration of the internal resolution process; encourages premature resort to federal court; and both creates and dramatically enhances the possibility that beneficiaries wrongfully deprived of their benefits will never have a chance to file a claim in court—even though ERISA explicitly guarantees beneficiaries "ready access to the Federal court." 29 U.S.C. § 1001(b).

Respondents recognize that their approach could yield a result that even they cannot defend: the complete elimination of a beneficiary's statutory right to seek judicial review of an ERISA benefits determination. To avoid this possibility, they urge this Court to adopt an extra-contractual, implied "reasonableness" requirement that would give ERISA beneficiaries the right to challenge a plan's accrual provision on a case-by-case basis. This approach is as awkward and inefficient as it sounds. In some cases, as Respondents acknowledge, a court would have to invalidate the provision; in others, the provision would be enforceable. No one—neither plans nor beneficiaries—would have any idea at the outset of a case whether a given accrual provision would stand or fall. Thus Respondents' approach deals a wild card into a regime that is designed to provide a uniform and predictable path to the fair resolution of benefit claims. Congress cannot have intended such a result.

OPINIONS BELOW

The summary order of the court of appeals (Pet. App. 1) is reported at 496 Fed. Appx. 129. The opinion of the district court (Pet. App. 5) is available at 2012 WL 171325.

JURISDICTION

The court of appeals' judgment was entered on September 13, 2012. The petition for a writ of certiorari was filed on December 11, 2012, and granted on April 15, 2013. This Court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTORY PROVISION INVOLVED

Section 502(a)(1)(B) of ERISA, codified at 29 U.S.C. § 1132(a)(1)(B), provides:

> A civil action may be brought—
>
> (1) by a participant or beneficiary—
>
> * * *
>
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan[.][1]

STATEMENT

A. Federal Statutory and Regulatory Background

This case involves employer-sponsored long term disability (LTD) insurance governed by ERISA. LTD insurance "provides income to workers whose earnings are interrupted by lengthy periods of disability." Diane B. Hill, *Employer-Sponsored Long-*

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[1] This brief will refer to 29 U.S.C. § 1132 as § 502 of ERISA.

Term Disability Insurance, 110 Monthly Lab. Rev. 16 (July 1987), *available at* http://www.bls.gov/opub/mlr/1987/07/art2full.pdf. Because LTD benefits, if granted, are usually payable until retirement age, employer-sponsored benefit plans play a crucial role for employees by providing "a bridge between short-term disability benefits and retirement income." *Id.* ERISA-governed employer-sponsored LTD insurance constitutes the primary source of this type of private insurance in the United States. *See* Paul Fronstin, Employee Benefit Research Institute, No. 347, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2010 Current Population Survey* 1 (2010) *available at* http://www.ebri.org/pdf/briefspdf/EBRI_IB_09-2010_No347_Uninsured1.pdf.

ERISA-governed LTD plans provide income protection to more than 46 million Americans, approximately one-third of the country's workforce. *See* Am. Council of Life Insurers, Private Long-Term Disability Income Insurance 1 (2010) *available at* http://www.acli.com/Consumers/Disability%20Income%20Insurance/Documents/PrivateLTDI.pdf; Bureau of Labor Statistics, Insurance Benefits (2012) *available at* http://www.bls.gov/ncs/ebs/benefits/2012/ownership/private/table12a.pdf. This case, therefore, has implications for an enormous number of workers across the country.

1. ERISA's Dual Goals

Two Congressional goals lie at the heart of ERISA: "promot[ing] the interests of employees and their beneficiaries in employee benefit plans" and "protect[ing] contractually defined benefits" to which those employees and beneficiaries are entitled. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101,

113 (1989) (citations omitted). As this Court has explained, Congress sought to avoid a regulatory regime "so complex that administrative costs, or litigation expenses" would dissuade an employer from electing to offer benefits in the first place, while at the same time establishing sufficient procedural safeguards and enforcement mechanisms that would secure employees' contractually promised benefits. *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987).

The result was a "comprehensive," "reticulated," and carefully "crafted" statute that strikes a balance between these competing interests. *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146-47 (1985). "Nothing in ERISA requires employers to establish employee benefit plans," just as nothing in the statute mandates "what kind of benefits employers must provide if they choose to have such a plan." *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996). But once an employer elects to provide benefits (in whatever form), ERISA imposes a series of "higher-than-marketplace" procedural safeguards, coupled with a set of enforcement mechanisms, designed to protect an employee's interest in those benefits. *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 115 (2008); *see also Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 830 (2003).

2. ERISA's Remedial Regime

Nowhere is Congress' careful balancing more evident than in ERISA's remedial framework, which combines a mandatory internal claims process with judicial review of individual claim denials under § 502(a)(1)(B). *Glenn*, 554 U.S. at 115 (observing that ERISA "supplements marketplace and regulatory controls with judicial review"). This framework

stands as "one of the essential tools for accomplishing the stated purposes of ERISA," *Pilot Life*, 481 U.S. at 52, by "ensuring fair and prompt enforcement of rights under a plan," while avoiding regulatory complexity that might discourage employers from offering benefits. *Conkright v. Frommert*, 559 U.S. 506, 130 S. Ct. 1640, 1649 (2010).

a. As virtually every circuit has held, the benefit claim process begins with the mandatory requirement that every claimant pursue, and then exhaust, a benefits claim through a plan's own internal procedures before filing suit under § 502(a)(1)(B). *See LaRue v. DeWolff, Boberg & Assocs., Inc.*, 552 U.S. 248, 258 (2008) (Roberts, C.J.. concurring) (discussing the "requirement, recognized by almost all the Courts of Appeals, *see Fallick v. Nationwide Mut. Ins. Co.*, 162 F. 3d 410, 418, n.4 (CA6 Cir. 1998) (citing cases), that a participant exhaust the administrative remedies mandated by ERISA § 503, 29 U.S.C. § 1133, before filing suit under § 502(a)(1)(B)").

Under § 503, an ERISA plan must establish an internal claims procedure that includes an opportunity for a participant to file an initial claim for benefits with her plan. *See* 29 U.S.C. § 1133(1). If the plan denies the claim, it must provide the participant with adequate notice of the decision and the reasons for the denial. *See id.* Then, the plan must provide at least one opportunity for an internal appeal of the initial adverse decision. *See id.* § 1133(2).

These procedural requirements are fleshed out by federal regulations that establish, among other things, time limitations for both the initial "adverse

benefit determination" and any appeal therefrom. 29 C.F.R. § 2560.503-1(f)(3). In particular, a plan has up to 105 days to initially decide a claimant's benefits claim. *Id.* (45 days with two 30-day extensions possible); *see also* 65 Fed. Reg. 70246, 70249 (2000).

Then, a claimant must be given *at least* 180 days following notification of an adverse benefit determination within which to appeal the adverse determination. *See* 29 C.F.R. § 2560.503-1(h)(3)(i), (h)(4). Once an appeal has been filed, an LTD plan has up to 90 days to resolve the appeal. *Id.* § 2560.503-1(i)(1)(i), (i)(3) (45 days with one 45-day extension possible). Importantly, however, these time limitations are not unyielding.

During both the initial determination phase and the appeal, the time limitations may be tolled indefinitely when a plan determines it needs more information from the claimant. Once a plan notifies the claimant that it needs more information, the clock stops running until the claimant responds to the request for additional information. *See id.* § 2560.503-1(f)(4), (i)(4). Under this framework, the internal claims process is open-ended. It could take less than one year, but could also last years if the periods are tolled.

This mandatory internal process was designed to serve several key purposes: to "reduce the number of frivolous law-suits under ERISA; to promote the consistent treatment of claims for benefits; to provide a nonadversarial method of claims settlement; and to minimize the cost of claims settlement for all concerned." *Schorsch v. Reliance Standard Life Ins. Co.*, 693 F.3d 734, 739 (7th Cir. 2012) (internal citations omitted). *See also Harrow v. Prudential Ins. Co. of Am.*, 279 F.3d 244, 249 (3d Cir. 2002); *Kennedy*

v. Empire Blue Cross & Blue Shield, 989 F.2d 588, 594 (2d Cir. 1993); *Amato v. Bernard*, 618 F.2d 559, 567 (9th Cir. 1980).

Fortunately for the overburdened federal courts, the data bear out these goals. Hundreds of thousands of benefit claims are filed annually. *See, e.g.*, Council for Disability Awareness, 2012 Long Term Disability Claims Review 2 (2012) *available at* http://www.benefitdesignltd.com/pdfs/Resources/CDA_LTD_Claims_Survey_2012.pdf (estimating the number of LTD claims alone at well over 600,000). Yet only a small fraction of these claims end up in federal court. *See* U.S. Courts, Judicial Facts and Figures 3 (2011) *available at* http://www.uscourts.gov/uscourts/Statistics/JudicialFactsAndFigures/2011/Table404.pdf (reporting that 8,860 ERISA cases were filed in 2011).

b. Consistent with the above, it is only after a beneficiary exhausts her plan's internal benefits resolution procedures that ERISA provides a statutory right to file a denial-of-benefits claim in federal court under § 502(a)(1)(B). This claim is a beneficiary's "exclusive vehicle" for challenging a plan's "improper processing of a claim for benefits." *Pilot Life*, 481 U.S. at 52. And it "lies at the heart of [ERISA]," *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58. 65 (1987), because it "protect[s] contractually defined benefits." *Firestone Tire*, 489 U.S. at 113.

ERISA itself does not provide a statute of limitations for denial-of-benefits claims. When faced with such claims, federal courts typically apply state breach-of-contract limitations periods, which range from three to fifteen years. *See, e.g., Wetzel v. Lou Ehlers Cadillac Grp. Long Term Disability Ins. Program*, 222 F.3d 643, 648 (9th Cir. 2000) (citing

cases); *Wise v. Verizon Commc'ns, Inc.*, 600 F.3d 1180, 1187 (9th Cir. 2010); *Meade v. Pension Appeals & Review Comm.*, 966 F.2d 190, 194-95 (6th Cir. 1992). For the majority of denial-of-benefit claims, these state limitations periods begin to run from the date a beneficiary's claim is finally denied by the plan under its mandatory internal review procedure—in other words, from the date a beneficiary could bring her claim challenging a plan's denial of her benefits in court. *See Held v. Mfrs. Hanover Leasing Corp.*, 912 F.2d 1197, 1205 (10th Cir. 1990) ("Uniformly, courts recognize that an ERISA cause of action accrues when an application for benefits is denied.").

B. The Hartford Plan, Which Closely Tracks Connecticut Law

1. This case involves several provisions in an ERISA welfare plan that purport to govern the time limits for challenging the denial of a claim for disability benefits. The plan at issue was issued and administered by Respondent Hartford, a Connecticut-based entity that offers insurance under ERISA as well as a wide array of other circumstances. *See* The Hartford, Insurance Plans for Individuals & Families, http://www.thehartford.com/insurance-individuals/ (last visited June 19, 2013).

In relevant part, the Hartford ERISA plan contains two provisions that provide:

> Written proof of loss must be sent to The Hartford within 90 days after the start of the period for which The Hartford owes payment.
>
> * * *

> Legal action cannot be taken against The Hartford:
>
> (1) Sooner than 60 days after due proof of loss has been furnished; or
>
> (2) After the shortest period allowed by the laws of the state where the policy is delivered. This is three years after the time written proof of loss is required to be furnished according to the terms of the policy.

Br. in Opp'n (BIO) App. 5a, 7a.

Together, these two provisions establish a limitations period—three years—that begins to run from a specific point: the time written proof of loss is required to be furnished under the plan. Here, that date is, in effect, 90 days from when a beneficiary becomes eligible for long-term disability benefits. *Id.* at 5a.

2. As it turns out, Connecticut state insurance law requires individual health insurance policies (though not group policies, like the plan in this case) to include a very similar set of provisions. First, Conn. Gen. Stat. § 38a-483(a)(7) requires individual health insurance policies to include the following proof-of-loss language:

> PROOFS OF LOSS: Written proof of loss shall be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ninety days after the termination of the period for which the insurer is liable and in case of claim for any other

> loss within ninety days after the date of such loss.

Conn. Gen. Stat. § 38a-483(a)(7). Second, Conn. Gen. Stat. § 38a-483(a)(11) requires that every individual health insurance policy set forth the following limitations period:

> No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Conn. Gen. Stat. § 38a-483(a)(11).[2]

3. Hartford's plan incorporates much of the language in these two provisions. But the provisions operate very differently in the two contexts. Because Connecticut insurance law (like that of many states), does not require an insurance policyholder to exhaust an internal claims process before proceeding to court, an accrual provision that starts the clock running when proof of loss is due does not interfere with a policyholder's ability to seek legal relief for her claims in a timely fashion. Instead, a policyholder may file a legal action as soon as the short, definite 60-day waiting period has elapsed, even if the insurance company has yet to act. *See,*

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[2] Forty-two other states mandate the inclusion of similar provisions in insurance policies. *See Wetzel*, 222 F.3d at 647 & 647 n.5.

e.g., *Peloso v. Hartford Fire Ins. Co.*, 267 A.2d 498, 501 (N.J. 1970).[3]

ERISA beneficiaries, in contrast, must exhaust a lengthy internal process before they may file a civil claim in court. This means that a virtually identical accrual provision, when applied to an ERISA beneficiary, creates a perverse set of incentives that—as described below—are contrary to the interests of all ERISA stakeholders.

Even though state insurance law does not require ERISA's form of mandatory exhaustion before a legal claim can be filed, there are state-law settings that do. It is telling that, in such settings, states (including Connecticut) toll the running of any limitations period until the pre-suit process is exhausted. *See Coelho v. ITT Hartford*, 752 A.2d 1063, 1068 (Conn. 1999); *N.H. Div. of Human Servs. v. Allard*, 644 A.2d 70, 72 (N.H. 1994) (listing cases applying this "general rule").

C. This Litigation

1. Background

Julie Heimeshoff worked for Wal-Mart Stores, Inc., for nearly twenty years, rising to the position of Senior Public Relations Manager. Pet. App. 6. Although she began experiencing the chronic pain and fatigue associated with fibromyalgia in the 1990s, Ms. Heimeshoff continued to work for many years. JA 53. Over time, however, her fibromyalgia, lupus, and other conditions worsened, and, by June

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[3] Respondents concede that Connecticut's statutory insurance provisions, which only govern individual insurance policies, do not apply to their group insurance plan. BIO at 22 n.11. They nonetheless chose to import these Connecticut provisions into their ERISA plan, albeit in slightly modified form.

2005, the pain and fatigue had become so debilitating that Ms. Heimeshoff was forced to leave Wal-Mart. Pet. App. 6.

As part of her benefits package, Ms. Heimeshoff was eligible for Wal-Mart's group LTD plan, which is administered by Hartford. Pet. App. 6. Accordingly, on August 22, 2005, after Ms. Heimeshoff was no longer able to work, she timely applied for LTD benefits. Pet. App. 7. She supported her application with her doctor's diagnoses of lupus and fibromyalgia. *Id.* She was not represented by a lawyer.

The Plan did not respond with either an approval or a denial. Rather, three months later, on November 21, 2005, the Plan informed Ms. Heimeshoff that it needed more information from Ms. Heimeshoff's doctor regarding her functionality and that, if she did not respond within 21 days, she risked a denial. JA 6, 8. The letter claimed to be the "last request" for the information from the Plan. *Id.* at 6. On November 29, 2005, the Plan sent her another letter, again requesting the functionality information and saying that once it had the information, it expected to make a decision within 30 days. *Id.* at 9.

However, on December 8, 2005, before the original 21-day period for providing additional information expired, and one week after sending the second letter, the Plan denied Ms. Heimeshoff's claim. *Id.* at 11-15. The Plan explained that it was denying the claim because it had not received the functionality information. *Id.* at 13. The denial letter described the procedures and timelines for internally appealing the decision and explained that Ms. Heimeshoff could not bring an ERISA suit until her internal appeals had been exhausted. *Id.* at 14-15. It

also explained that Ms. Heimeshoff could provide additional materials in support of her appeal. *Id.*

Ms. Heimeshoff then retained a lawyer to assist with her mandatory appeal. Her lawyer contacted the Plan within the appeal period outlined in the denial stating that Ms. Heimeshoff was appealing the decision and requesting the record. *Id.* at 16-19. In response, the Plan stated that an appeal was inappropriate and that once the Plan acquired the functionality information, it would "re-open" her claim. *Id.* at 21. To ensure that, this time, the Plan would have all of the information it claimed was needed, Ms. Heimeshoff arranged to undergo a two-day functionality evaluation by a specialist. Pet. App. 8. Acquiring the specialist's evaluation and report required time. *See* JA 24-25.

After Ms. Heimeshoff obtained and submitted the evaluation and report, as well as other additional medical records, on November 29, 2006, the Plan again denied Ms. Heimeshoff's claim. *Id.* at 22-27. Because it had "re-opened" Ms. Heimeshoff's claim instead of permitting her to appeal the December 2005 decision, the 2006 denial letter stated that she needed to appeal the new decision before she would be able to go to court and, again, explained that she could submit additional information. *See id.* at 21, 27.

Within the time period provided for appeal, Ms. Heimeshoff again informed the Plan that she was appealing the denial of benefits and requested additional time; Ms. Heimeshoff wanted to maximize her chances of getting the denial reversed and more time was needed to accommodate the additional experts' schedules. *Id.* at 28-29. However, Ms. Heimeshoff's appeal was ultimately denied on

November, 26, 2007, more than two years after she filed her claim and approximately two years from the date proof of loss was due. *See* Pet. App. 7, 14. The appeal denial letter, which stated that it was the Plan's "final decision," explained that now Ms. Heimeshoff could bring an ERISA suit in court, but did not explain what, if any, time limits applied for doing so. JA 59.

On November 18, 2010—fewer than three years after the Plan's final denial—Ms. Heimeshoff brought this suit in federal court, challenging the Plan's adverse benefit decision. *Id.* at 1, 60.

2. Proceedings Below

In November 2010, Ms. Heimeshoff filed this ERISA suit in federal district court challenging the Plan's denial of disability benefits under § 502(a)(1)(B), alleging that the decision to deny her benefits was arbitrary and capricious, that the Plan violated the terms of the plan documents, and that the Plan violated ERISA's requirements that the Plan follow a particular process and issue certain notices. *Id.* at 76-78. She also alleged, under § 502(a)(2), that the Plan breached its fiduciary duty and sought further equitable relief under § 502(a)(3). *Id.* at 78-82.

In response, Respondents moved to dismiss Ms. Heimeshoff's suit as time-barred. Pet. App. 5. They argued that Ms. Heimeshoff's claim was untimely because it was filed more than three years after proof of loss was due. *Id.* at 13. The district court agreed, rejecting Ms. Heimeshoff's argument that, among other things, the limitations period in the plan was unenforceable because the time for filing suit was not laid out in the denial letters, in violation of U.S. Department of Labor regulations. *Id.* at 15-18.

Ms. Heimeshoff appealed to the U.S. Court of Appeals for the Second Circuit. She argued that, under federal law, a claim accrues and the limitations period begins to run when the plaintiff is able to file to her claim in court—here, when the Plan denied her final appeal in November 2007. Appellant's Br. 36-44. Therefore, she argued, even assuming the validity of the three-year limitations period, her claim was timely. In addition, Ms. Heimeshoff argued that because the Plan violated the regulatory notice requirements, which required the Plan to notify Ms. Heimeshoff of her deadline to file in court, the limitations period was unenforceable, or, in the alternative, the limitations period should be tolled. *Id.* at 20-38, 48-51.

The Second Circuit rejected Ms. Heimeshoff's arguments in a summary order. Pet. App. 1-2. The court relied on its prior decision in *Burke v. PriceWaterHouseCoopers LLP Long Term Disability Plan*, 572 F.3d 76 (2d Cir. 2009), which held that a limitations period could run before a claimant can bring suit. Pet. App. 3. Ms. Heimeshoff then sought certiorari, which this Court granted.[4]

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[4] In their opposition brief, Respondents argued that "petitioner's focus on 'accru[al]' is misleading," because that term refers only to when "a beneficiary's right to bring suit under Section 502(a) arises." BIO at 10-11. That is wrong. "Accrual" can refer both to the time a statute of limitations starts running on a claim and to the time a claim is ripe to be filed in court. *See, e.g., Reiter v. Cooper*, 507 U.S. 258, 267 (1993) (discussing both uses). This case is about the former—when a claim accrues for limitations purposes—not the latter. *See* Pet. at i ("When should a statute of limitations accrue for judicial review of an ERISA disability adverse benefit determination?").

SUMMARY OF ARGUMENT

The question in this case is whether the statute of limitations for challenging benefit denials under § 502(a)(1)(B) of ERISA starts to run when the benefits are finally denied, or whether, as Respondents contend, the limitations period begins to run whenever the plan says it does, unless a federal court decides that the plan's accrual provision is not "reasonable" in the specific case before it. Respondents agree that a federal denial-of-benefits claim cannot be filed in court until the plan-provided internal remedies have been exhausted. BIO at 11. They argue, however, that ERISA allows them to start the limitations clock running on that claim at some time before exhaustion—here, at the time proof of loss is due, near the beginning of what can prove to be a very lengthy internal claims process, a process that could outlast the entire limitations period.

Nothing about Respondents' approach—neither its attempt to manipulate the accrual date of a federal denial-of-benefits cause of action nor its extra-contractual case-by-case "reasonableness" inquiry—can be squared with ERISA, blackletter federal accrual law, or state law.

1. It has been settled law for nearly two centuries that, unless Congress affirmatively specifies otherwise in the statute itself, the limitations period on a federal claim does not begin to run until that claim can be filed in court. *See Clark v. Iowa City*, 20 Wall. 583, 589 (1875) ("All statutes of limitation begin to run when the right of action is complete. . . .")

A beneficiary's denial-of-benefits claim under § 502(a)(1)(B) incorporates this standard rule and accrues for limitations purposes only when an ERISA plan finally denies a beneficiary's claim for benefits, which is when a beneficiary can actually file her claim in court. Although Congress can pass a statute that "create[s] a cause of action that accrues at one time for the purpose of calculating when the statute of limitations begins to run, but at another time for the purpose of bringing suit," it may only achieve this "odd result" by explicitly saying so in the legislation itself. *Reiter*, 507 U.S. at 267. No such command can be found anywhere in ERISA for § 502(a)(1)(B) claims challenging a denial of benefits.

This is the only rule that makes sense in light of ERISA's mandatory exhaustion requirement, which requires that beneficiaries pursue their benefits claims through plan-provided internal procedures before seeking any judicial review. Indeed, a § 502(a)(1)(B) claim like the one at issue here challenges a plan's (allegedly) *wrongful* denial of benefits—a claim that does not come into existence until the plan actually denies benefits. A contractual accrual provision, like Respondents', that starts the clock ticking on a beneficiary's claim before that claim even exists, gives fresh meaning to the word Kafkaesque.

2. The Second Circuit lost sight of this rule based on three mistakes of law. First, it believed that state law, not federal law, governs the question of accrual. This was error. *See Wallace v. Kato*, 549 U.S. 384, 388 (2007). Second, it erred in pointing to the state insurance law framework, which permits proof-of-loss accrual dates for insurance claims in a context where there is no mandatory exhaustion

requirement. That framework is not analogous and cannot be used as a model for how ERISA accrual should work. Third, it ignored the well-established rule under both state and federal law that, where an administrative or other proceeding must be completed before a plaintiff can file suit, the limitations period for filing suit is tolled while the plaintiff pursues the prerequisite proceeding.

3. Finally, Respondents' approach undermines ERISA's carefully crafted remedial regime. Starting the clock ticking on a denial-of-benefits claim before exhaustion of the internal resolution process, and keeping it running while that process is ongoing, thwarts ERISA's interlocking and mutually reinforcing benefit-determination process. *See White v. Sun Life Assurance Co. of Canada*, 488 F.3d 240, 247-48 (4th Cir. 2007). It discourages comprehensive and good-faith internal resolution of disputes and creates the very real risk that a beneficiary's right to file a federal denial-of-benefits claim will be completely eliminated. Moreover, because the limitations period would vary for every claimant, in every case, depending on various factors, including the length of the mandatory internal review process, Respondents' rule unavoidably sows uncertainty and unpredictability.

Faced with the untenable possibility that its approach will lead to the extinguishment of the federal denial-of-benefits claim, Respondents proffer a truly unworkable "solution"—an extra-contractual "reasonableness" requirement, read into every ERISA plan, that compels a judge to evaluate the running of a plan's limitations period on a case-by-case basis according to a standard that has never been defined at all, let alone with any precision. *See*

id. at 248. Under this regime, nobody (not even the plan administrator) would have any idea at the outset how much time a beneficiary would have to file a federal court challenge to a denial of benefits or if the running of the limitations clock would ultimately be enforceable. That approach violates ERISA's written plan requirements and this Court's repeated admonition that ERISA "is built around reliance on the face of written plan documents." *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 83 (1995).

At its core, Respondents' approach "leaves the law more uncertain, more unpredictable than it found it." *Glenn*, 554 U.S. at 122 (Roberts, C.J., concurring). No stakeholder benefits from such a regime.

ARGUMENT

I. The Respondents' Accrual Rule Contravenes Federal Law.

A. The Limitations Period on a Federal Claim Begins to Run Only When a Plaintiff Can Bring Her Claim in Court.

It has been the settled rule—"since the 1830s," *Gabelli v. SEC*, ___ U.S. ___, 133 S. Ct. 1216, 1220-21 (2013)—that, for limitations purposes, a federal cause of action does not accrue until "the plaintiff has a complete and present cause of action." *Bay Area Laundry & Dry Cleaning Pension Trust Fund v. Ferbar Corp. of Cal., Inc.*, 522 U.S. 192, 201 (1997) (internal citations omitted). That straightforward rule does not permit a limitations clock to run on a federal claim until "the plaintiff can file suit and obtain relief." *Id.* at 201; *see also Clark*, 20 Wall. at 589 ("All statutes of limitation begin to run when the

right of action is complete. . . ."); *Wallace*, 549 U.S. at 388 (reiterating *Bay Area Laundry*'s rule).

This rule applies to statutory causes of action that do not otherwise identify a specific accrual date. As this Court has held time and again, when Congress does not specifically identify an accrual date for a federal cause of action, it is the "standard rule that the limitations period commences when" the plaintiff "can file suit and obtain relief," and not, as Respondents would have it, at any time before. *Bay Area Laundry*, 522 U.S. at 201; *see Graham Cnty. Soil & Water Conservation Dist. v. United States ex rel. Wilson*, 545 U.S. 409, 418 (2005) (explaining that the Court has "repeatedly recognized that Congress legislates against the standard rule that the limitations period commences when the plaintiff has a complete and present cause of action"); *see also TRW, Inc. v. Andrews*, 534 U.S. 19, 37 (2001) (Scalia, J., concurring) ("Congress has been operating against th[is] background rule . . . for a very long time."); *Spannaus v. U.S. Dep't of Justice*, 824 F.2d 52, 56-57 n.3 (D.C. Cir. 1987) (noting that it is "virtually axiomatic" that a statute of limitations "cannot begin to run against a plaintiff *before* the plaintiff can maintain suit in court" (emphasis in original)).

For federal claims, like the one at issue here, that are expressly conditioned on the exhaustion of a mandatory pre-suit process—administrative or private—this rule means that a limitations clock does not start running on the claim until that process is complete. That is true of virtually every federal statutory claim that is predicated upon the

exhaustion of mandatory pre-suit procedures.[5] *See, e.g.*, *Bowen v. City of New York*, 476 U.S. 467, 478 (1986) (Social Security Act) (limitations period for filing Social Security Act claims in court begins to run after administrative remedies have been exhausted); *Spannaus*, 824 F.2d at 56-57 (FOIA) ("Tautologically, a suit cannot be maintained in court—and a cause of action does not first accrue—until a party has exhausted all administrative remedies whose exhaustion is a prerequisite to suit."); *U.S. Dep't of Labor v. Old Ben Coal Co.*, 676 F.2d 259, 261 (7th Cir. 1982) (the Coal Act) ("In the context of the Coal Act the district court claim accrues only after the administrative proceeding has ended . . . .").[6]

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[5] As explained *infra* in Part II.C, the only exceptions to the rule that the limitations period begins to run when pre-suit procedures are exhausted are regimes in which courts apply tolling rules to stop the running of the limitations clock until the administrative or internal process is complete. *See, e.g.*, *Walker v. Sheahan*, 526 F.3d 973, 978 (7th Cir. 2008) (prisoner claims brought under the Prison Litigation Reform Act).

[6] *See also Muwekma Ohlone Tribe v. Salazar*, 708 F.3d 209, 218-19 (D.C. Cir. 2013) (Indian Reorganization Act) ("Muwekma's termination of recognition claim was subject to administrative exhaustion and thus did not accrue until . . . Interior issued its Final Determination."); *Ortiz v. Sec'y of Def.*, 41 F.3d 738, 743 (D.C. Cir. 1994) (Army Board for Correction of Military Records Act) ("Although *Spannaus* is not controlling . . . its logic is unassailable: a statute of limitations will not normally begin to run until a party has acquired the right to initiate the proceeding covered by the limitations period."); *Wind River Mining Corp. v. United States*, 946 F.2d 710, 716

All these cases recognize, implicitly or explicitly, that it is nonsensical to start a limitations clock running before exhaustion when exhaustion is mandatory. That logic does not apply, however, where the pre-suit process is *not* mandatory. In such cases this Court has made clear that a limitations clock *can* begin to run before complete exhaustion. *See Johnson v. Ry. Express Agency, Inc.*, 421 U.S. 454, 461 (1975) (limitations clock begins running at time of injury for § 1981 claim because, unlike his Title VII claim, "Petitioner freely concedes that he could have filed his § 1981 action at any time after his cause of action accrued"); *cf. McMahon v. United States*, 342 U.S. 25, 27-28 (1951) (seaman's Suits in Admiralty Act claim begins running from date of injury because administrative claim, if not rejected within 60 days, is "presumed to have been administratively disallowed and the claimant shall be entitled to enforce his claim [in court]"). These cases only underscore the rule that, where a plaintiff *is* required to exhaust before suit, the clock on his

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(9th Cir. 1991) (Federal Land Policy and Management Act) (holding that a "substantive challenge to an agency's decision" accrues for limitations purposes upon the completion of the administrative proceedings); *United States v. Meyer*, 808 F.2d 912, 916 (1st Cir. 1987) (Export Administration Act) ("All of the analogous authority appears to concur with the general rule that if disputes are subject to mandatory administrative proceedings before judicial action may be taken, then the claim does not accrue until their conclusion.") (internal quotations omitted).

judicial claim does not start until that mandatory process is complete.[7]

B. An ERISA Denial-of-Benefits Claim Under § 502(a)(1)(B) Hews to this Standard Rule.

ERISA operates no differently from all these examples. The standard rule of accrual applies. As this Court has explained, a § 502(a)(1)(B) claim challenges the "*wrongful denial* of benefits." *Varity*, 516 U.S. at 512 (emphasis added); *see also Pilot Life*, 481 U.S. at 52 (characterizing claim as one for "*improper* processing of a claim for benefits" (emphasis added)). Because a plan's improper denial gives rise to the civil claim, it defies logic to assert that the claim accrues—and the limitations period

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[7] This rule has also been applied to claims under § 301 of the Labor Management Relations Act (LMRA), after which ERISA's § 502(a) enforcement scheme was modeled. *See UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 346 n.7 (1999). Section 301 claims arise when an employer has violated the terms of a collective bargaining agreement (CBA) and the employee's union has failed in its duty to represent the employee fairly. 29 U.S.C. § 185; *see also DelCostello v. Int'l Bhd. of Teamsters*, 462 U.S. 151, 163-72 (1983). In such cases, it is well established that the clock on the employee's claim does not begin to run until either the employee has exhausted the CBA's grievance process or it becomes clear that exhaustion is impossible or would be futile. *See, e.g., Konen v. Int'l Bhd. of Teamsters*, 255 F.3d 402, 406 (7th Cir. 2001) (employee's LMRA claim accrues when "a final decision on [his] grievance has been made or from the time [he] discovers, or in the exercise of reasonable diligence should have discovered, that no further action would be taken on his grievance"); *Chapple v. Nat'l Starch & Chem. Co. & Oil*, 178 F.3d 501, 505 n.4 (7th Cir. 1999).

starts running—before that allegedly improper decision is made.

So reasoned this Court in *Crown Coat Front Co. v. United States*, 386 U.S. 503 (1967), which rejected an effort to start the clock running on a federal claim before the wrongful act has taken place or, in other words, before injury. There, this Court held that a contractor's federal cause of action did not—indeed, could not—accrue for limitations purposes until the administrative process was complete because "[t]he focus of the court action is the validity of the administrative decision, . . . until that decision is made . . . [the contractor] cannot know what claim he has or on what grounds administrative action may be vulnerable." *Id.* Exactly the same logic applies to a § 502(a)(1)(B) denial-of-benefits claim.

To see why Respondents' rule can yield illogical results, consider the case of a beneficiary who initially receives disability benefits from her plan only to have them terminated several years later. If the limitations period really runs from the proof-of-loss date, as Respondents contend it should, then the clock is running on a beneficiary's denial-of-benefits claim while the beneficiary is actually receiving benefits. This scenario has occurred more than once. *See, e.g.*, *Abena v. Metro. Life Ins. Co.*, 544 F.3d 880 (7th Cir. 2008); *Skipper v. Claims Servs. Int'l*, 213 F. Supp. 2d 4 (D. Mass. 2002).

This Court has already rejected an effort to start the clock running on a claim under ERISA at some point before the claim becomes ripe for filing in federal court. *See Bay Area Laundry*, 522 U.S. at 200-01. There, though Congress supplied a limitations period for the claim—a pension plan's action to recover unpaid withdrawal liability under

the Multiemployer Pension Plan Amendments Act (MPAAA)—it did not specify when the claim accrued for purposes of the limitations period. *Id.* at 201. The Ninth Circuit held that the limitations period began to run from the date the employer withdrew from the plan, or, in other words, "at a time when the [plaintiff] could not yet file suit." *Id.* at 200. This Court rejected that result as "inconsistent with basic limitations principles," concluding that, because a plaintiff could not maintain an action under the MPAAA until an employer missed a scheduled withdrawal payment, the limitations period "does not begin to run until that time." *Id.* at 200-01.

So too here. Like the Ninth Circuit in *Bay Area Laundry*, the Second Circuit held that, under ERISA, the limitations period for a § 502(a)(1)(B) claim challenging the denial of benefits could legally commence "from the time that written proof of loss was due under the plan" Pet. App. 3, or, in other words, "at a time when the [plaintiff] could not yet file suit." *Bay Area Laundry*, 522 U.S. at 201. But ERISA affords "no basis to obtain relief" on that date, *id.*, so the lower court was wrong. A beneficiary simply has no claim until her plan denies her claim for benefits, and the limitations period (whatever length it is) cannot begin to run until then. *Cf. Meyer*, 808 F.2d at 919 (refusing to "read this sort of anomaly into [a] statutory scheme" requiring administrative exhaustion absent "some clear demonstration that Congress intended" to create the possibility "of such a grotesque analemma").

Congress can, of course, pass a statute that "create[s] a cause of action that accrues at one time for the purpose of calculating when the statute of limitations begins to run, but at another time for the

purpose of bringing suit." *Reiter*, 507 U.S. at 267. Although rare, it has done so before, *see Dodd v. United States*, 545 U.S. 353, 359-60 (2005), though never, to Petitioner's knowledge, in the context of a statute, like ERISA, that imposes a mandatory internal pre-suit process which itself forms the basis of the federal claim. But, although Congress is free to provide "such an odd result," *Reiter*, 507 U.S. at 369, it may do so only by explicitly saying so in the statutory text. *TRW, Inc.*, 534 U.S. at 37 ("When [Congress] has wanted us to apply a different rule, . . . it has said so.") (Scalia, J., concurring); *Cloer v. Sec'y of Health & Human Servs.*, 654 F.3d 1322, 1333 (Fed. Cir. 2011) (a challenger faces a "heavy burden of proving that Congress intended the odd result of breaching the firm default rule," and "meant to divorce the date of accrual of [a] cause of action from the date that the statute of limitations begins to run"). No such command can be found anywhere in ERISA for § 502(a)(1)(B) claims challenging a denial of benefits.

Tellingly, however, ERISA does include specific accrual dates for fiduciary breach claims arising under § 502(a)(2). *See* 29 U.S.C. § 1113. Thus, Congress knew how to depart from the settled rule by using the type of clear statement required by this Court's precedents. That Congress deliberately decided not to do that for the claim at issue here speaks volumes; that choice may not be tampered with. *Russell*, 473 U.S. at 147 ("We are reluctant to tamper with an enforcement scheme crafted with such evident care as the one in ERISA."); *cf. Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 837-38 (1988) ("[W]e are hesitant to adopt an interpretation of a congressional enactment which

renders superfluous another portion of that same law.").

Unhappy with the settled rule that a denial-of-benefits claim accrues—for limitations purposes—when a beneficiary can file her claim in federal court, Respondents simply propose a different one: that where "nothing in [the statute] precludes" a party from altering an accrual date for limitations purposes, such an alteration is permissible. BIO at 22. That rule turns the settled law on its head and must be rejected. *See Crown Coat*, 386 U.S. at 514; *see also TRW, Inc.*, 534 U.S. at 38 (Scalia, J., concurring) ("To apply a new background rule to previously enacted legislation would reverse prior congressional judgments; and to display uncertainty regarding the current background rule makes all unspecifying new legislation a roll of the dice.").

II. State Law Cannot Justify an Accrual Provision that Runs the Limitations Period on an ERISA Denial-of-Benefits Claim While a Beneficiary Is Exhausting Her Internal Remedies.

Nothing in state law justifies the Second Circuit's conclusion that an ERISA plan can run the clock on a federal denial-of-benefits claim while a beneficiary pursues her plan's mandatory pre-suit process. In upholding an ERISA plan's accrual provision doing this, the Second Circuit made a series of related errors: (1) it improperly concluded that state law, not federal law, governs accrual under ERISA; (2) it misguidedly looked to provisions of state insurance law as proof that ERISA plans could run their limitations period from when proof of loss is due; and (3) it failed to take into account state tolling law that would toll the running of the limitations clock until a beneficiary's claim could be filed in court, after

exhausting the internal procedures. Any one of these errors is reason enough to reject the Second Circuit's rule.

A. Federal, Not State, Law Governs When the Limitations Period for an ERISA Claim Begins to Run.

The Second Circuit's first mistake was in relying on its controlling predecessor *Burke*, 572 F.3d 76, which conflated the source of law governing *accrual* of a federal claim with the law governing the application of a *limitations period*. In the *Burke* court's view, both are governed by reference to state law. *See, e.g., id.* at 79 (concluding that an ERISA plan could alter the accrual date because "here, as allowed under New York law, the Plan specifies the limitations period will begin to run at a different time than when a claimant could bring a federal action"). Thus, according to the Second Circuit in *Burke*, the fact that *state law* permitted alteration of accrual dates was "reason to infer the odd result that the limitations period began to run prior to the time [a beneficiary] could file suit in federal court." *Id.* (internal citations omitted); *see also* Pet. App. 3 ("In this Circuit, a statute of limitations specified by an ERISA plan for bringing a claim under 29 U.S.C. § 1132 may begin to run before a claimant can bring a legal action.") (citing *Burke*, 572 F.3d at 81).

This conclusion, however—that state law governs both a federal claim's limitations period *and* its accrual date for purposes of measuring the limitations period—is mistaken. Accrual is a question of *federal* law, not state law. *Wallace*, 549 U.S. at 388. So, where a federal statute is silent on both the limitations period and the accrual date for a specific federal cause of action, courts (in general)

must "look[] to the law of the State in which the cause of action arose . . . for the length of the statute of limitations." *Id.* at 387. "[T]he accrual date," in contrast, "is a question of federal law that is *not* resolved by reference to state law." *Id.* at 388 (emphasis in original). *See also Miller v. Fortis Benefits Ins. Co.*, 475 F.3d 516, 520 (3d Cir. 2007) ("[T]he accrual date for federal claims is governed by federal law, irrespective of the source of the limitations period.").

B. The State-Law Insurance Framework Is Inapposite Because, Unlike ERISA, It Does Not Require Exhaustion.

Compounding its legal mistake, the Second Circuit also erred in its reading of state-law accrual rules. Both the Second Circuit and Respondents claim that state insurance proof-of-loss provisions show that the Plan's approach here is both widely accepted and sound public policy. *See Burke*, 572 F.3d at 81; BIO at 3 ("In the vast majority of States, insurance contracts are required by law to include proof-of-loss limitations language similar to [the Plan's] provision." (citing *Wetzel*, 222 F.3d at 647 n.5)). This reading ignores an important fact about these state-law provisions that render them inapposite in the ERISA context: They are not employed in conjunction with a lengthy and open-ended mandatory administrative exhaustion period. That fact makes all the difference between a context in which an accrual provision tied to the proof-of-loss date makes sense and one in which such a provision tramples on the rights of beneficiaries.

Consider, for example, the state-law accrual provision cited in *Burke*. 572 F.3d at 78-79. Under New York insurance law, a policyholder must only

wait a short period—just 60 days from when she files a claim under her policy—before suing in court to recover under the policy. *See id.* (discussing N.Y. Ins. Law § 3221(a)(14)). Coupled with New York's two-year limitations period, a policyholder knows with certainty that she will have one year and 10 months from the date proof of loss is due to bring her claim in court. None of this certainty exists in the ERISA benefits process. No one can consult the plan documents and know precisely how much time a beneficiary will have to file a denial-of-benefits claim because whether and when the benefits will be denied depends on the contents, outcome, and length of the internal review process—which, in turn, depend on a host of variables that cannot be predicted in advance.

Given these differences, state law accrual provisions that start the limitations clock running when proof of loss is due have no place in the context of ERISA—and the Second Circuit's conclusion to the contrary must be rejected.

C. Even If the Limitations Period Begins to Run at Proof-of-Loss, Under Both State and Federal Law, the Limitations Period Is Tolled During Mandatory Exhaustion.

Finally, even if the Second Circuit were right that a plan could alter ERISA's accrual date and start the limitations clock ticking before a beneficiary has completed the mandatory internal process, it would be wrong not to follow state-law tolling rules. When federal statutes do not specify a limitations period, as for ERISA in denial-of-benefits claims, federal courts borrow analogous state limitations periods. *Johnson*, 421 U.S. at 462. Along with those limitations periods, federal courts also borrow the

state tolling rules. *Hardin v. Straub*, 490 U.S. 536, 539, 540 (1989). And in virtually every state, when there is a mandatory administrative or other process the potential plaintiff must exhaust before filing suit, the limitations period does not run while the process is pending.

All relevant sources—treatises, state laws, and analogous federal settings—bear this out. It is standard textbook law that, where an administrative or other proceeding must be completed before a plaintiff can file suit, the limitations period for filing suit is tolled while the plaintiff pursues the required proceeding. Corman, Limitations of Actions § 8.4.1, at 15-16 (1991); 51 Am. Jur. 2d Limitation of Actions § 186 (2013). *See also Harris v. Alumax Mill Prods., Inc.*, 897 F.2d 400, 404 (9th Cir. 1990) ("[T]olling is most appropriate when the plaintiff is *required* to avail himself of an alternate course of action as a precondition to filing suit." (emphasis in original) (internal quotations omitted)); *Trent v. Bolger*, 657 F.2d 837, 659 (4th Cir. 1988) ("[W]hen an employee is required to exhaust an administrative remedy, the applicable limitations period . . . is tolled pending the exhaustion of that administrative remedy.").

State courts consistently follow this rule. For example, in several states, broad statutory or judicial tolling rules apply in all cases in which a pre-suit proceeding is required. As the California Supreme Court has explained, "[i]t has long been settled . . . that whenever the exhaustion of administrative remedies is a prerequisite to the initiation of a civil action, the running of the limitations period is tolled during the time consumed by the administrative proceeding." *Elkins v. Derby*, 525 P.2d 81, 83-84 (Cal. 1974) (interpreting Cal. Civ. Pro. Code § 356). *See*

735 Ill. Stat. Comp. 5/13-216 (when commencement of an action is delayed by statutory prohibition, the limitations period does not run during the delay); *Ragland v. Alpha Aviation, Inc.*, 686 S.W.2d 391, 393 (Ark. 1985) (explaining that where an individual is prevented from filing a claim by the pendency of other proceedings, that pendency will toll the statute of limitations); *Allard*, 644 A.2d at 72 (endorsing general rule that tolling applies when an administrate proceeding is a prerequisite to a civil action and rejecting the argument that a plaintiff ought to file a suit and seek a stay instead); *W.V. Pangborne & Co. v. N.J. Dep't of Transp.*, 562 A.2d 222, 228 (N.J. 1989) (tolling requires that the prerequisite proceedings be mandatory).

Other states' laws address this type of tolling in the context of specific mandatory pre-suit proceedings. In Georgia, for example, limitations periods are tolled when the pendency of a worker's compensation claim prohibits an employee from filing suit. *Butler v. Glen Oak's Turf, Inc.*, 395 S.E.2d 277, 280 (Ga. Ct. App. 1990). Likewise, the Supreme Court of Michigan has held that statutes of limitation are tolled while a party exhausts mandatory grievance procedures provided in collective bargaining agreements. *Am. Fed'n of State, Cnty. & Mun. Emps., AFL-CIO, Mich. Council 25 & Local 1416 v. Highland Park Sch. Dist. Bd. of Educ.*, 577 N.W.2d 79, 86-91 (Mich. 1998). The same tolling rule applies to habeas claims in Kansas, Kan. Stat. Ann. § 60-1501, and discrimination claims with mandatory pre-suit proceedings in Minnesota, *Sigurdson v. Isanti Cnty.*, 433 N.W.2d 910, 913 (Minn. Ct. App. 1988) *aff'd* 448 N.W.2d 62 (Minn. 1989).

Connecticut law does the same: In every instance where there is a mandatory pre-suit proceeding and the claim accrues before the proceeding has concluded, the limitations period for the later-filed suit is tolled during the pendency of the earlier proceeding. *See Perzanowski v. City of New Britain*, 440 A.2d 763, 765 (Conn. 1981). For example, in the underinsured motorist insurance context, the limitations period is tolled while the potential plaintiff exhausts the limits of liability under the tortfeasor's policy—a process that must be completed before a motorist can file a claim on his or her underinsurance policy. Conn. Gen. Stat. § 38a-336(g).[8] Similarly, Connecticut law provides for the tolling of the limitations period for an attorney malpractice claim where the potential plaintiff does not have a complete claim until earlier litigation has concluded. *Fontanella v. Marcucci*, 877 A.2d 828, 834-35 (Conn. Ct. App. 2005). In short, under Connecticut law—as in virtually all other states—where there is a mandatory pre-suit proceeding, the limitations period is tolled for the duration of that proceeding.

This tolling rule is also found in analogous federal contexts. In *Johnson*, 421 U.S. at 460, for example, this Court held that because a plaintiff need not exhaust his Title VII administrative remedies before

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[8] Tolling under Connecticut's underinsured motorist statute comes into play only when the insurance policy sets the accrual date prior to exhaustion. Without such a policy term, the limitations period starts running for an underinsured motorist claim against the insurer when the plaintiff exhausts the limits of liability under the tortfeasor's policy—that is, when the claim can be brought in court. *Coelho*, 752 A.2d at 1066-69.

filing a § 1981 discrimination claim—that is, because administrative exhaustion was not required before he could file his claim—the limitations period for the § 1981 claim was not tolled during the administrative proceedings. *Id.* 465-66. In other words, whether or not the limitations period is tolled for the pendency of an earlier proceeding depends on whether that proceeding is a mandatory prerequisite to suit: If it is mandatory, tolling is appropriate, if not, then there is no tolling.

Federal courts also apply the principle that limitations periods are tolled while mandatory pre-suit procedures are being exhausted in the closely analogous context of § 1983 claims brought by prisoners. Just as ERISA contains no statute of limitations for § 502(a)(1)(B) claims, neither does § 1983, forcing courts to look to state statutes of limitations in both instances. *See Wilson v. Garcia*, 471 U.S. 261, 266-67 (1985). And, as in ERISA denial-of-benefits cases, the Prison Litigation Reform Act requires prisoners filing § 1983 claims challenging their prison conditions to first exhaust internal prison review processes; that is, prisoners must exhaust the prison grievance procedure before they can sue in court. 42 U.S.C. § 1997e(a). Thus, as in the ERISA context, the exhaustion requirement, absent tolling, gives the potential defendant (the prison) the opportunity to delay the mandatory internal review process until the limitations period has expired. Faced with this concern, federal courts of appeal have nearly unanimously held that the limitations periods for prisoners' § 1983 claims are

tolled while the prisoners exhaust the prisons' internal grievance systems.[9]

In other contexts, too, federal courts have recognized that limitations periods are tolled while potential plaintiffs are exhausting mandatory pre-suit proceedings. For example, the tolling rule is recognized in disputes over government contracts, *N. Metal Co. v. United States*, 350 F.2d 833, 838-39 (3d Cir. 1965), cases brought to enforce civil rights, *Bd. of Educ. v. Wolinsky*, 842 F. Supp. 1080, 1085 (N.D. Ill. 1993), and cases enforcing workers' rights, *Harris*, 897 F.2d at 404; *Trent*, 837 F.2d at 659; *Brennan v. W. Nat'l Mut. Ins. Co.*, 125 F. Supp. 2d 1152, 1156 (D.S.D. 2001); *Kolomick v. United Steelworkers of Am., Dist. 8, AFL-CIO*, 762 F.2d 354, 356 (4th Cir. 1985); *Taylor v. Standard Ins. Co.*, 28

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[9] *Gonzalez v. Hasty*, 651 F.3d 318, 323-24 (2d Cir. 2011) (following other federal circuits); *Walker*, 526 F.3d at 978 (following *Johnson v. Rivera*, 272 F.3d 519 (7th Cir. 2001)); *Brown v. Valoff*, 422 F.3d 926, 943 (9th Cir. 2005) (following other federal circuits); *Johnson v. Rivera*, 272 F.3d at 522 (applying Illinois tolling law); *Brown v. Morgan*, 209 F.3d 595, 596 (6th Cir. 2000) (following other federal circuits); *Harris v. Hegmann*, 198 F.3d 153, 158 (5th Cir. 1999) (applying Louisiana tolling law); *Jackson v. Johnson*, 950 F.2d 263, 266 (5th Cir. 1992) (applying Texas tolling law). *See also Roberts v. Barreras*, 109 F. Appx. 224, 226-27 (10th Cir. 2004) (remanding for district court to determine whether tolling was warranted under New Mexico law); *Leal v. Ga. Dep't of Corrections*, 254 F.3d 1276, 1280 (11th Cir. 2001) (reversing dismissal and remanding for district court to address tolling question). *But see Braxton v. Zavaras*, 614 F.3d 1156, 1162 (10th Cir. 2010) (finding no automatic tolling under Colorado law).

F. Supp. 2d 588, 592 n.3 (D. Haw. 1997). *See also Conley v. Int'l Bhd. of Elec. Workers, Local 639*, 810 F.2d 913, 915 (9th Cir. 1987) (Kennedy, J.) ("Equitable tolling is most appropriate when the plaintiff is required to avail himself of an alternate course of action as a precondition to filing suit."). So long as the exhaustion is mandatory, courts have consistently found that the limitations period for the court action does not run while the mandatory procedures are ongoing. *See* Corman, Limitations of Actions § 8.4.1, at 10, 15-16.[10]

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All this tolling makes sense, especially given that running the limitations period during internal review would permit the entity conducting the review to delay the proceedings until the limitations period expired. *Id.* § 8.4.1, at 16. This possibility is particularly problematic where, as in ERISA, the reviewing entity is also the potential defendant. In any event, in light of the substantial body of tolling law that exists in myriad other comparable contexts, the Second Circuit's refusal to toll the limitations

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[10] For cases applying this principal to ERISA denial-of-benefits claims, see *Zorn v. Principal Life Ins. Co.*, No. 6:09-cv-81, 2012 WL 112949, at *11-*12 (S.D. Ga. Jan. 12, 2012); *Hinojos v. Prudential Ins. Co. of Am.*, Civ. No. 10-1193, 2011 WL 7768621, at *7 (D.N.M. Oct. 19, 2011); *Amos v. Hartford Life & Accident Ins. Co.*, No. CV-08-BE-2165-M, 2009 WL 1804989, at *2 (N.D. Ala. June 24, 2009) *aff'd* 362 Fed. Appx. 48 (11th Cir. 2010); *Rodolff v. Provident Life & Accident Ins. Co.*, No. 01-CV-0768, 2002 WL 32072401, at *3-*4 (S.D. Cal. Apr. 5, 2002); *Jeffries v. Trustees of Northrop Grumman Sav. & Inv. Plan*, 169 F. Supp. 2d 1380, 1382-83 (M.D. Ga. 2001); *Wolfe v. 3M Short Term Disability Plan*, 176 F. Supp. 2d 911, 916-18 (D. Minn. 2001).

clock in this context provides yet another reason why the dismissal of Petitioner's suit was improper.

III. Respondents' Accrual Rule Undermines ERISA's Carefully Crafted Regime.

Respondents' approach not only flies in the face of the settled standard rules of accrual for federal claims and generally applicable tolling requirements, it also violates the letter and spirit of ERISA itself. By permitting plans to start the clock running on a denial-of-benefits claim before the plan has denied the claim, Respondents' rule undermines the internal benefit resolution process while simultaneously weakening ERISA's civil enforcement protections. Respondents' proposed fix to these problems—grafting an ad hoc "reasonableness" analysis onto the ERISA remedial scheme—only does further damage to the certainty-focused ERISA regime.

A. Respondents' Rule Thwarts ERISA's Remedial Scheme.

A rule that would start the clock ticking on a federal denial-of-benefits claim before that claim ever comes into existence would undermine the very backbone of ERISA's core effort to "protect [employees'] contractually defined benefits," *Russell*, 473 U.S. at 148 (internal citations omitted), by discouraging good-faith pursuit of the plan-provided internal proceedings while at the same time hamstringing the civil judicial review protections. As the court in *White* explained, Respondents' rule "would allow one remedy to undercut the other." 488 F.3d at 247-48. ERISA cannot countenance this disruption of Congress' carefully balanced remedial framework.

ERISA's mandatory internal benefits resolution process serves several important purposes. First, it

"encourag[es] resolution of benefits disputes through internal administrative proceedings rather than costly litigation." *Conkright*, 130 S. Ct. at 1649. Second, resolving disputes internally, without resort to the federal courts, "promotes efficiency," *id.*, because it allows parties to employ streamlined procedures, without formalities introduced by the judicial process. *See, e.g.*, *Woodford v. Ngo*, 548 U.S. 81, 89 (2006) ("Claims generally can be resolved much more quickly and economically in [non-judicial] proceedings . . . than in litigation in federal court."); *Amato*, 618 F.2d at 567 (by instituting an administrative claim-resolution procedure in ERISA, Congress created a "nonadversarial method of claims settlement" that minimized costs for all concerned).

Third, requiring exhaustion helps set the stage for judicial review by incentivizing parties to "develop a full factual record" and enabling courts to "take advantage of agency expertise." *Janowski v. Int'l Bd. of Teamsters Local No. 710 Pension Fund*, 673 F.2d 931, 935 (9th Cir. 1983), *vacated on other grounds*, 463 U.S. 1222 (1983). Giving a plan first-crack at resolving a beneficiary's benefit claim not only minimizes premature judicial intervention, but it also streamlines it, by ensuring that "the facts and the administrator's interpretation of the plan may be clarified for the purposes of subsequent judicial review." *Ames v. Am. Nat'l Can Co.*, 170 F.3d 751, 756 (7th Cir. 1999); *Kross v. W. Elec. Co.*, 701 F.2d 1238, 1245 (7th Cir. 1983) (ERISA's mandatory internal resolution process serves the purpose of "refining and defining the problem in given cases, [and] may well assist the courts when they are called upon to resolve the controversies.").

Under Respondents' approach, all of these key goals would be frustrated. Beneficiaries who recognize that they risk losing their ability to challenge a plan's benefits denial in court may feel compelled to prospectively protect their rights by early resort to federal court. *See, e.g.*, *Rush Prudential HMO, Inc. v. Morgan*, 536 U.S. 355, 394 n.5 (2002) (explaining that suits under § 502(a)(1)(B) include obtaining "a declaratory judgment that one is entitled to benefits"); *cf. Johnson*, 421 U.S. at 465 (noting the possibility, "although perhaps not a highly satisfactory one," that a plaintiff in a § 1981 suit "may ask the court to stay proceedings until the administrative efforts at conciliation and voluntary compliance have been completed"). That would benefit no one, including plans, which would have to defend these suits. *See Franconia Assocs. v. United States*, 536 U.S. 129, 146 (2002) ("Putting prospective plaintiffs to the choice of either bringing suit [early] or forever relinquishing their claims would surely proliferate litigation."); *cf. Northern Metal*, 350 F.2d at 839 ("The dockets of the courts are too crowded for Congress to have intended that suits must be brought while the [internal tribunal] is engaged in ascertaining the facts which will determine [whether the plaintiff has a claim].").

Moreover, Respondents' approach invites beneficiaries to shy away from good-faith efforts to resolve their benefits claims privately, especially in cases where a plan has made several requests for additional information. Worried that responding to these open-ended requests will run down the clock on her civil claim, a beneficiary might, for instance, abandon the internal appeal after initial denial. This approach would result in a suboptimal record for judicial review and would prevent the plan from self-

correcting errors during the internal appeal. This Court has previously voiced its displeasure with accrual rules that might produce this result. *Cf. Franconia*, 536 U.S. at 146 (refusing to permit the limitations clock to start ticking on a Tucker Act breach of contract claim before "the time performance is due" because, if the clock began ticking any earlier, a party "would be compelled by the looming limitations bar to forgo the usual option of awaiting the time performance is due before filing an action for breach").

That a beneficiary will be forced into one of these unpalatable choices is made more likely by the fact that a plan's internal review process can exhaust the entire limitations period. The Second Circuit dismissed this possibility, believing that "strict adherence" to the Department of Labor's regulations would alleviate the concern. *See, e.g.*, *Burke*, 572 F.3d at 80 (internal citation omitted). This conclusion is at odds with the regulations themselves, which *authorize* indefinite tolling for acquisition of additional information during both the initial review process and the appeal. *See supra* at 7-8; 29 C.F.R. § 2560.503-1(f)(4). The Fourth Circuit reached exactly this conclusion in *White*. *See* 488 F.3d at 252 ("[T]he time limits prescribed in the regulations are themselves somewhat elastic and do not apply to all of the time what would be counted against a claimant.").

Ironically, under Respondents' approach, it is the beneficiary who makes a non-adversarial, good-faith effort to resolve a benefit claim internally is most at risk of losing the right to file a civil claim. Benefit claims often produce requests for additional information, and these requests, like the internal

review process generally, take time. *See supra* 7-8. Indeed, a plan often makes multiple requests at different intervals, as occurred here. *See supra* 14-16. The process can be delayed even further by a plan's decision to re-open a beneficiary's initial benefits claim rather than allow her to appeal. *See id.* In short, a beneficiary like Ms. Heimeshoff, who complies in good faith with her plan's various requests in the hope that she can win benefits without resort to court, may very likely end up hung out to dry—with no benefits and no opportunity to obtain judicial review. An outcome like this one, that results in the "underenforcement of beneficiaries' statutory rights," squarely conflicts with ERISA. *See Russell*, 473 U.S. at 147.

The upshot is a trilemma of equally undesirable options: pursue the internal review process as thoroughly and diligently as possible and risk the possibility of losing the right to judicial review; file protectively in court, risking dismissal and potentially incurring significant costs; or race through the internal process, at the risk of creating a weak record, in an effort to ensure the right to federal-court review. Whatever the choice, Congress could not have intended that its carefully integrated remedial scheme be undermined in this way.

B. Respondents' Rule Requires an Impermissible Extra-Contractual Inquiry that Frustrates the Interests of All Stakeholders.

Respondents' suggested solution to these serious concerns—a judge-made "reasonableness" requirement read into every ERISA plan—only makes matters worse. *See* BIO at 24 (arguing that the best approach, given the possibility that a beneficiary could lose her federal claim entirely is "a

case-by-case inquiry into the reasonableness of the limitations period"). Such a requirement injects substantial uncertainty into both a beneficiary's and a plan's rights, promotes disuniformity in the application of a limitations period for federal denial-of-benefit claims, and removes the plan from the center of ERISA, replacing it with a judge's impression of what is reasonable in a particular case.

1. "[O]ne of ERISA's central goals is to enable plan beneficiaries to learn their rights and obligations at any time." *Curtiss-Wright*, 514 U.S. at 83. That goal is achieved through "a scheme that is built around reliance on the face of written plan documents." *Id.*; *see also U.S. Airways, Inc. v. McCutchen*, ___ U.S. ___, 130 S. Ct. 1537, 1548 (2013) ("ERISA's focus [is] on what a plan provides" and "is built around reliance on the face of written plan documents" (internal citation omitted)). As this Court observed in *Curtiss-Wright*, a "written plan is to be required in order that every employee may, *on examining the plan documents*, determine exactly what his rights and obligations are under the plan." 514 U.S. at 83 (internal citation omitted) (emphasis in original).

Under Respondents' "reasonableness" rule, reliance on the plan goes out the window. Neither employee nor fiduciary would, upon examining the face of the plan documents, be able to ascertain with any certainty whether the contractual accrual/limitations provision would ultimately be enforced by a court. That is so because the answer would depend, in every case, on how long the internal review process ultimately took and how much time was left on the clock—and then determining whether the amount of time left over is

"reasonable." *See, e.g.*, *White*, 488 F.3d at 249 (explaining that a "sometimes-enforcing approach . . . would disregard the written plan requirement" itself, since the "reasonableness" inquiry is "nowhere contained in [the] plan").

The uncertainty created by Respondents' "reasonableness" rule is not at all academic. Consider the case of an employee who becomes disabled and (without a lawyer) files a claim for long term disability benefits that is finally denied by her plan two years and 10 months after proof of loss was due. She seeks to challenge this denial in court. Consulting her plan documents, however, she discovers that the plan includes an altered accrual date that started her three-year limitations period running back at the time "written proof of loss was due under the terms of the plan."

How should a beneficiary in that case evaluate her potential rights to seek judicial review? For that matter, how would a plan evaluate the same scenario? Would a court uphold the plan's limitations approach or invalidate it? And, since most beneficiaries retain a lawyer only after final denial, how should the lawyer counsel his potential client? No one could be sure whether the plan's tying of the limitations period to when proof of loss is due would be valid or not. How would all of this change if, instead of two months left, there were three months, or one? How is a court to determine how much time is "reasonable" under the circumstances under all these shifting scenarios?

And what of the beneficiary who has "had his application for benefits approved, and has then been receiving benefits for a period of many years before being cut-off?" For her, the plan's accrual language is

"pure gobbledygook." *Skipper*, 213 F. Supp. 2d at 7; *Forrest v. The Paul Revere Life Ins. Co.*, 662 F. Supp. 2d 183, 191 (D. Mass. 2009) (concluding that the plan's approach offers "nothing intelligible that could fairly be said to limit the right of the insured to dispute the [benefits] termination" (internal quotations omitted)). In a case like *Skipper*, the plan's provision is in fact misleading, because it cannot possibly set forth the actual time limitation that will govern. *See White*, 488 F.3d at 249.

Imagine further that a court ultimately decides that a plan's tying of the deadline for filing suit to when written proof of loss is due is, in fact, unreasonable in a given case. How much more time should a beneficiary be entitled to receive before his claim is time-barred? *See, e.g.*, *Salisbury v. Hartford Life & Accident Co.*, 583 F.3d 1245, 1249 (suggesting that courts could fashion "a reasonable time after exhaustion of administrative remedies" but offering no guidance on what such a period might be). This Court has repeatedly made clear that ERISA is designed to prevent exactly these uncertainties, yet that is precisely what the "reasonableness" requirement demands.[11]

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[11] Respondents' effort to pay lip service to the principle of categorical plan enforcement, like the Second Circuit's, confuses the issue. *See* BIO at 11; *see also Burke*, 572 F.3d at 81 (justifying its holding in part because, "courts must not rewrite, under the guise of interpretation a term of the contract"). In reality, as Respondents themselves repeatedly acknowledge, their approach *requires* courts to evaluate these provisions—which couple a limitations period with an altered accrual date—on a "case-by-case" analysis and invalidate the ones that, in the circumstances of the particular case, the courts view as

2. Imposing an extra-contractual inquiry onto plan language that is required by statute to be clear and certain also invites a host of ancillary problems. First, satellite litigation is sure to follow concerning just what, under the circumstances of a particular case, constitutes a "reasonable" application of the running of a limitations period. *Conkright*, 130 S.Ct. at 1649-50 (cautioning against rules that "interject other additional issues into ERISA litigation" that would "increase litigation costs"). True, courts could police the outer bounds of reasonableness, by disregarding plan-specified accrual dates when a plan has taken so long to make a final determination that a claimant is left with no time to file suit. BIO at 15. But parties—and courts—would have no easy way to determine how much of a compression of the beneficiary's limitation period is too much, so they would litigate it.

Second, requiring courts to police the "reasonableness" of the running of a limitations period in every case invites disuniformity. *See Conkright*, 130 S. Ct. at 1650 (standards creating "ad hoc exceptions" are particularly disfavored because of the "uniformity problems that arise"). One court might believe that three months left after final denial is reasonable while another might disagree. A "patchwork of different interpretations" will develop for cases that come nearest to crossing from reasonable to unreasonable (whatever these terms mean). *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1987). That result, as this Court made clear,

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unreasonable. BIO at 12, 24. That admission deals a fatal blow to any suggestion that what is at stake here is an "enforce-the-terms-of-the-plan" rule.

"would introduce considerable inefficiencies in benefit program operation." *Id.* At its core, then, Respondents' approach "leaves the law more uncertain, more unpredictable than it found it." *Glenn*, 554 U.S. at 122 (Roberts, CJ, concurring). The Court should reject this untenable result.

CONCLUSION

The judgment below should be reversed and the case remanded for proceedings on the merits of Ms. Heimeshoff's claims.

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RESPONDENT'S BRIEF

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IN THE

Supreme Court of the United States

JULIE HEIMESHOFF,

Petitioner,

v.

HARTFORD LIFE & ACCIDENT INSURANCE CO. AND WAL-MART STORES, INC.,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR RESPONDENTS

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QUESTION PRESENTED

Whether a court should enforce a contractual limitations provision in an ERISA disability benefits policy requiring that any suit be brought within three years after the date proof of loss is due, where the claimant had actual knowledge of the limitations period and more than a year to file suit within that period after the final administrative denial of her claim.

CORPORATE DISCLOSURE STATEMENT

Hartford Life and Accident Insurance Company is a wholly owned subsidiary of Hartford Life, Inc., which is a wholly owned subsidiary of Hartford Holdings, Inc., which is a wholly owned subsidiary of The Hartford Financial Services Group, Inc. The Hartford Financial Services Group, Inc. is a publicly traded corporation that has no parent corporation, and no publicly held corporation owns 10 percent of more of its stock.

Wal-Mart Stores, Inc. has no parent corporation, and no publicly held corporation owns 10 percent or more of its stock.

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IN THE

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No. 12-729

JULIE HEIMESHOFF,

Petitioner,

v.

HARTFORD LIFE & ACCIDENT INSURANCE CO. AND WAL-MART STORES, INC.,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR RESPONDENTS

INTRODUCTION

Imagine a limitations provision in an ERISA plan requiring that any lawsuit challenging a denial of benefits be filed within one year after the final adverse decision. Petitioner does not dispute, and the United States effectively concedes (at 23 n.4), that such a provision would be valid. The provision at issue here permits suit up to three years after the claimant was required to submit proof of loss in support of her claim. The question presented is whether this three-year period is *un*enforceable—even though it gave petitioner *more* time to sue after the final adverse decision than

the one-year period would have allowed—because the three-year period ran from proof of loss, not from denial of the claim.

The answer must be determined by reference to ERISA's text and implementing regulations. Contracting parties may adopt a reasonable limitations provision and fix its duration, start date, and other features by agreement. As a matter of federal common law, such a provision is enforceable unless specifically prohibited by statute. ERISA, which protects the contractual terms upon which employers agree to provide benefits, contains no such prohibition. And although the Department of Labor's regulations closely govern the processing of benefit claims, they neither address nor prohibit the commonly used limitations provision at issue here. The provision is therefore enforceable, and it bars petitioner's claim.

Petitioner seeks a different result based not on ERISA's text or regulations, but on two principles she contends should be read into ERISA's silence. One principle derives from a rule of statutory interpretation this Court has applied to statutes of limitations that run from the time a cause of action "accrues." The other derives from ERISA's remedial scheme. Petitioner's reliance on each of these principles fails on its own terms. But a broader point also requires their rejection: Petitioner asks this Court to rewrite or ignore a plan term based on no more than a sense that the term seems "'odd'" or potentially inconsistent (in theory, though not in practice) with notions of fair remedial policy. Categorical invalidation of plan terms on such a basis would upend parties' reasonable reliance interests and defeat the purposes of ERISA's written plan requirement. That result would be particularly unwarranted here, where most States require insurance poli-

cies to include the limitations provision, where similar provisions have been widely used for decades without prejudicing diligent claimants, and where petitioner has never explained why she could not have filed her lawsuit years earlier.

STATEMENT

A. Hartford's Group Disability Insurance Policy

1. Disability insurance helps replace lost income for employees who become unable to work due to injury or illness. Many employers voluntarily offer disability insurance as a benefit to employees by purchasing a group disability insurance policy. In this case, respondent Wal-Mart provided disability benefits to its employees under a group insurance policy (the Policy) issued by respondent Hartford.

Under the Policy, Hartford pays benefits to qualifying Wal-Mart employees who become "totally disabled." As relevant here, the Policy defines "total disability" as an employee's inability, due to certain medical conditions, to perform the essential duties of her occupation. Opp. App. 2a. Hartford has discretion to determine a claimant's eligibility for benefits. CAJA34. To do so, it needs information about the claimant's medical condition and functionality, such as physician reports, medical records, or work history. An employee who has applied for benefits must therefore submit "proof of loss" describing the nature of the claim and substantiating her eligibility for benefits. Proof of loss is due "within 90 days after the start of the period for which The Hartford owes payment." Opp. App. 5a.[1]

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[1] Benefits for total disability become payable the day after a waiting period known as the "Elimination Period." Opp. App. 3a-

Hartford may also request other information from the claimant or from her physicians.

If Hartford denies a claim, the claimant may administratively appeal. Opp. App. 6a. If Hartford upholds the denial of benefits on appeal, the claimant may file a civil action challenging the denial of benefits under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1132(a).

The provision of the Policy at issue here sets time limits for a claimant to bring such a suit. The Policy provides:

> Legal action cannot be taken against The Hartford:
>
> (1) sooner than 60 days after due proof of loss has been furnished; or
>
> (2) after the shortest period allowed by the laws of the state where the policy is delivered. This is 3 years after the time written proof of loss is required to be furnished according to the terms of the policy.

Opp. App. 7a.

2. Limitations provisions requiring suit to be brought within a certain period after proof of loss is due have long been a common feature of disability and health insurance policies. Like any limitations provision, a contractual limitations provision in an insurance

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4a. As relevant here, the Elimination Period ends, and benefits become payable, when the employee has been totally disabled for 90 days or when Wal-Mart stops making salary continuation payments, whichever is later. Opp. App. 1a; Pet. App. 9.

policy assures fairness to defendants by "prevent[ing] fraudulent and stale claims from springing up at great distances of time." 16 *Couch on Insurance 3d* § 234:4 (2005) ("*Couch*"). Those interests are acute for insurers, who must be able to anticipate the timing and volume of claims for reserving and rate-setting purposes.

Insurance policies thus typically provide that any action must be commenced within a certain period of time after the insured loss, or the "inception of the loss," or the date by which "notice" or "proof of loss" is required. The standard fire insurance policy, for example, long required that any suit be commenced within 12 months "after the fire." *E.g.*, Darrach, *The Standard Fire Insurance Policy* 19 (1905); Jerry, *Understanding Insurance Law* § 85[b] ("Jerry"). Similarly, the limitations period for life insurance claims is "generally ... triggered by the death of the insured." 17 *Couch* § 236:30. And property insurance suits must typically commence within a certain period after the "date of the loss." *Id.* §§ 236:12, 236:22. Each of these formulations ties the start of the limitations period to the insured event (or something close to it), ensuring that any litigation will not be too remote in time from the events giving rise to the claim.

Disability and health policies have long included similar terms. For a century, the model laws of the National Association of Insurance Commissioners (NAIC) and its predecessor have required certain accident and health policies to include a limitations period running from the proof-of-loss deadline. *See* Uniform Individual Policy Provisions Law Model Bill of 1950, § 3(A)(11), *reprinted in* Meyer, *Life and Health Insurance Law* app. A, 860 (1971) (no action "after the expiration of three years after the time written proof of loss is required to be furnished"); Uniform Standard Provision

Bill of 1912, § 3(14), *reprinted in Proceedings of the National Convention of Insurance Commissioners* 123 (1912) (no action "unless brought within two years from ... the time within which proof of loss is required"). NAIC's current model law for group accident and health insurance continues to require a provision that "no action shall be brought at all unless brought within three (3) years from the expiration of the time within which proof of loss is required by the policy." Group Health Insurance Standards Model Act § 8(N), *reprinted in* NAIC, *Model Laws, Regulations and Guidelines* (2012).

The "vast majority" of States have adopted the NAIC model by "requir[ing] insurance contracts to include the proof of loss limitations language." *Burke* v. *PriceWaterhouseCoopers LLP Long Term Disability Plan*, 572 F.3d 76, 81 (2d Cir. 2009) (per curiam); *see also Wetzel* v. *Lou Ehlers Cadillac Group Long Term Disability Ins. Program*, 222 F.3d 643, 647 n.5 (9th Cir. 2000) (en banc) (listing statutes). As a nationwide insurer doing business in all 50 States, Hartford's policy language must, and does, conform to these state laws.[2]

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[2] The state laws all require a limitations provision running from the time proof of loss is due. They vary in the types of accident and health policies covered; in whether the insurer may seek approval to adopt a different period; and in the length of the limitations period. In addition to the 43 state laws identified in *Wetzel*, see also Fla. Stat. §§ 627.616, 627.657(3), 627.660(3)-(4); La. Rev. Stat. §§ 22:975(A), 22:986(B); N.D. Cent. Code § 26.1-36-05; Va. Code Ann. § 38.2-3540. Maryland law prohibits the enforcement of a limitations period shorter than that required by the State where the policy was issued or delivered. *See* Md. Ins. Code Ann., § 12-104(a). Utah and Wisconsin, rather than making the proof-of-loss limitations period a mandatory policy provision, provide statutes of limitations requiring suits on disability coverage to be brought

B. Ms. Heimeshoff's Disability Claim

Petitioner Julie Heimeshoff began working for Wal-Mart in 1986 and eventually became eligible for Wal-Mart's group disability plan. Pet. App. 6. On August 22, 2005, Ms. Heimeshoff submitted a claim for long-term disability benefits, asserting that she could no longer work due to pain and fatigue. Pet. App. 7. Ms. Heimeshoff supported her application with a statement by her rheumatologist, who diagnosed lupus and fibromyalgia. *Id.*

According to the terms of the Policy, Ms. Heimeshoff was required to submit proof of loss by December 8, 2005.[3] Throughout September and October 2005, Hartford obtained medical records, collected information about her work duties, and interviewed Ms. Heimeshoff about her condition. To determine whether Ms. Heimeshoff met the Policy's definition of "total disability," however, Hartford also needed information regarding her functionality and whether she could perform sedentary work. Hartford accordingly sent several faxes in October and November 2005 to the rheumatologist Ms. Heimeshoff had identified as her attending physician requesting that information. JA6. Those requests went unanswered. On November 21, 2005, Hartford sent another request to the rheumatologist

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within three years after proof of loss is due, Wis. Stat. § 631.83(1)(b), or three years after inception of the loss, Utah Code Ann. § 31A-21-313(1).

[3] Ms. Heimeshoff stopped working on June 8, 2005. Pet. App. 6. Because Wal-Mart continued paying her salary through September 8, 2005, *see* CAJA126; Pet. App. 7, the Elimination Period ended on that day, and any benefits owed would have become payable the next day, September 9, 2005. Ms. Heimeshoff's proof of loss was due 90 days later, on December 8, 2005.

and wrote to Ms. Heimeshoff, urging her to have her doctor return the requested information. JA6-8. Ms. Heimeshoff did not respond. Hartford wrote to her again on November 29, 2005, explaining that it still had not received the requested information and that it "c[ould] not make a claim decision without this information." JA9-10. Ms. Heimeshoff again failed to provide the information. Pet. App. 7-8; JA13-14.

On December 8, 2005, Hartford denied Ms. Heimeshoff's claim for "failure to 'provide satisfactory Proof of Loss.'" Pet. App. 8; *see* JA11-15. Hartford explained that it could not determine whether Ms. Heimeshoff was "totally disabled" within the meaning of the Policy without the information it had requested about her functionality, but stated that it would consider that information if she submitted it as soon as possible. JA13-14. Hartford also advised Ms. Heimeshoff of her right to appeal by submitting a written request for review within 180 days. JA14.

Five months later, Ms. Heimeshoff obtained counsel. Pet. App. 8. On May 18, 2006, Ms. Heimeshoff's counsel wrote to Hartford to confirm her intent to appeal and to request an additional 180 days in which to "submit additional information in support of [her] claim." JA17, 19. Counsel also requested a copy of the Policy and the administrative record. *Id.* On May 31, 2006, Hartford provided the requested materials, including the Policy, which stated the three-year limitations period. In its cover letter, Hartford reiterated that it had not denied Ms. Heimeshoff's claim based on a finding that she was not "totally disabled," but that it had been unable to determine whether she qualified for benefits without the requested information about her functionality. JA20-21. Given that circumstance, Hartford explained that it would reopen Ms. Heimeshoff's

claim without any need for a formal appeal if it received the information it had previously requested. *Id.* In subsequent correspondence, Hartford clarified that Ms. Heimeshoff could choose either to submit the requested information to reopen her claim without appealing or proceed with an appeal immediately. App. 10a. Ms. Heimeshoff elected to reopen her claim and sought a further extension of time to do so. App. 12a-13a.[4]

On October 2, 2006, Ms. Heimeshoff submitted additional information, including physician reports and the results of a physical capacity evaluation. Pet. App. 8. Hartford retained an independent rheumatology consultant and reopened Ms. Heimeshoff's claim as requested. Pet. App. 9; JA25.[5] On November 29, 2006, Hartford notified Ms. Heimeshoff of its determination that she did not meet the definition of "total disability." JA22-27. Hartford explained that its consultant had reviewed all the information in the file and concluded that Ms. Heimeshoff "'was able to physically perform the activities of her sedentary occupation.'" JA25. Hartford noted among other things that "[e]xams, including [by] a team of physicians at the Mayo Clinic, have consistently revealed no exam findings except for tender points." JA25. Hartford again advised petitioner of her right to appeal by submitting a request for re-

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[4] This correspondence, reproduced in the Appendix to this brief, was part of the claim file that Ms. Heimeshoff "incorporate[d]" into her complaint "as if annexed [t]hereto." JA61 n.1; *see* Pet. App. 10-12.

[5] The Brief in Opposition mistakenly stated (at 5) that Hartford's consultant spoke with Ms. Heimeshoff's rheumatologist. In fact, the rheumatologist refused to speak to Hartford's consultant by phone and failed to respond to a follow-up letter. JA25.

view within 180 days and of her "right to bring a civil action under Section 502(a) of ERISA." JA26-27.

Nearly 180 days later, on May 24, 2007, Ms. Heimeshoff sought an extension of time to appeal until September 30, 2007. Pet. App. 14; JA28-29. Hartford agreed. Pet. App. 14-15. On September 26, 2007, Ms. Heimeshoff submitted her appeal, JA32-49, and Hartford began an administrative review with the assistance of two new physician-consultants, Pet. App. 9.[6] At the end of that review, on November 26, 2007, Hartford concluded again that Ms. Heimeshoff was not "totally disabled" and upheld the denial of her claim. Pet. App. 9; *see* JA50-59. Hartford explained that, after a detailed review, Hartford's new rheumatology consultant agreed that Ms. Heimeshoff "retain[ed] the residual physical capacity to perform sedentary work, and therefore ha[d] the work capacity to perform her occupation." JA52. Hartford's consulting neuropsychologist also explained that the "available data ... d[id] not indicate restrictions or limitations." JA56. Hartford concluded that "the weight of the medical and vocational evidence in our file" indicated that Ms. Heimeshoff "is able to perform at least sedentary full time work and [that] her own occupation is identified within that capacity. Because she is employable in her own sedentary work, she is not disabled and the decision to deny [long-term disability] benefits was correct under the terms of the policy." JA58.

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[6] Ms. Heimeshoff's appeal materials included a note from her rheumatologist "declin[ing] Hartford's request" to provide any information about her functionality, "as that [wa]s outside his specialty." JA40.

C. This Litigation

For nearly three years, Ms. Heimeshoff took no further action. On November 18, 2010—nearly five years after the proof-of-loss deadline—Ms. Heimeshoff filed this action against Hartford and Wal-Mart, alleging that Hartford abused its discretion in denying her claim. JA60-83. She was represented by the same law firm that handled her administrative appeal four-and-a-half years earlier, *compare* JA16, *with* JA60, and the complaint rested solely on information in the administrative record or on "information and belief," JA60-83.

Respondents moved to dismiss the complaint as untimely under the Policy's limitations provision, and the district court granted the motion. Pet. App. 5-6. The court explained that the Policy "unambiguously disallows legal action more than three years after the time written proof of loss is required to be furnished." Pet. App. 15. Even crediting Ms. Heimeshoff's argument that proof of loss was not due until September 30, 2007—the date of the extension Hartford had agreed to for her administrative appeal, *supra* p. 10—the district court held that Ms. Heimeshoff's suit was untimely. Pet. App. 15.[7] The court also rejected Ms. Heimeshoff's

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[7] The parties disputed below whether Hartford's agreement to extend the deadline for the administrative appeal altered the proof-of-loss deadline. As Hartford explained, the Policy gave Ms. Heimeshoff until December 8, 2005 to submit proof of loss. Although an insurer's demand for new or additional proof of loss could reset the proof-of-loss deadline in some circumstances, that did not occur where Hartford merely allowed Ms. Heimeshoff more time to appeal. Resp. C.A. Br. 8-11, 29-32. Even under Ms. Heimeshoff's view, however, the latest date proof of loss could have been due was September 30, 2007. This suit was filed more than three years after that date. Pet. App. 15.

argument that Hartford's failure to state the limitations provision in its letters denying her claim precluded Hartford from enforcing the time bar. Pet. App. 15-18. Interpreting ERISA's implementing regulations, the court held that "Hartford was not required to inform Ms. Heimeshoff of the [Policy]'s limitations period for legal action in its benefits determination letter." Pet. App. 17-18.

On appeal, Ms. Heimeshoff argued primarily that Hartford should be precluded from enforcing the limitations provision, or that the period should be equitably tolled, because Hartford's denial letters had not stated the time limits for filing suit. Pet. C.A. Br. 12-36, 47-51. In the alternative, Ms. Heimeshoff argued that the limitations period could not begin to run until Hartford denied her administrative appeal because her cause of action did not accrue until she exhausted her administrative remedies. *Id.* at 37-44.

The court of appeals rejected both arguments and affirmed. Pet. App. 1-4. Noting that "federal law controls the accrual date of [a] party's claim," the court relied on circuit precedent holding that "it does not offend [ERISA] to have the limitations period begin to run before the claim accrues." Pet. App. 3 (citing *Burke*, 572 F.3d at 81). Applying the Policy's limitations provision as written, the court held that Ms. Heimeshoff's action was time-barred because she filed it "more than three years after her proof of loss was due." *Id.*

The court also refused to apply equitable tolling. The court noted that Ms. Heimeshoff's counsel conceded he had received a copy of the Policy containing the limitations provision "long before the three-year period ... had expired." Pet. App. 4. In light of Ms. Heimeshoff's actual knowledge of the time limits for

suing, she was "not entitled to equitable tolling," regardless whether Hartford had provided inadequate notice in its denial letters. *Id.*

SUMMARY OF ARGUMENT

The Policy's limitations provision is enforceable because nothing in ERISA's text or implementing regulations prohibits it. This Court has long held that contracting parties may design and adopt a reasonable limitations period to govern their agreement and that such a provision is enforceable "absen[t] ... a controlling statute to the contrary." *Order of United Commercial Travelers of Am.* v. *Wolfe*, 331 U.S. 586, 608 (1947). That principle dovetails with ERISA's singular focus on contractually defined benefits, which likewise requires that the terms upon which an employer agreed to provide benefits shall govern unless they violate a specific prohibition or requirement in the statute or regulations. Under these controlling rules, the absence of any provision in ERISA or its regulations prohibiting enforcement of the Policy's commonly used limitations provision is dispositive.

Ms. Heimeshoff's efforts to overcome ERISA's silence take two tacks, neither of which succeeds. First, she contends that ERISA incorporates a background "rule" of federal law—one which parties may never contract around—that the limitations period on a federal cause of action cannot run from a point in time different from the point when the plaintiff has a complete and present cause of action. The rule Ms. Heimeshoff cites, however, is a default rule of statutory interpretation courts have invoked to identify the time of "accrual" when a statute of limitations runs from the time a cause of action "accrues." That rule has no bearing on provisions that key the start of the limitations period to

a date other than "accrual" of the cause of action. And it does not address, much less restrict, the terms parties may choose when adopting a limitations provision by contract.

Second, Ms. Heimeshoff asserts that the limitations provision violates ERISA's remedial scheme because the provision *might* leave a claimant with too little time to sue, or *might* frustrate the internal review process in rare cases. That speculation is baseless. Although this limitations provision has been in widespread use throughout ERISA's lifetime, neither Ms. Heimeshoff nor the United States cites *any* evidence that the harms they fear have occurred in any kind of systemic way. That is not surprising. Regulatory deadlines governing the administrative review process, combined with the generous length of the limitations period, make it virtually impossible for the internal review to consume a claimant's time for seeking judicial review.

If enforcement of the limitations provision ever actually resulted in unfair prejudice to a diligent claimant, a court would address that circumstance by applying the same tools courts have always applied in conjunction with statutes of limitations—estoppel and waiver, equitable tolling, and the reasonableness requirement. Those tools are adequate to ameliorate any unfairness that might arise in exceptional cases, while respecting the terms of the plan. Contrary to Ms. Heimeshoff's contention, allowing for case-specific adjustment on the rare occasions it is necessary does not rewrite or cloud the meaning of the Policy's limitations provision any more than it does when applied to an ordinary statute of limitations.

Every court of appeals but one to have considered the question has thus concluded that nothing in

ERISA's remedial scheme precludes enforcement of the proof-of-loss limitations provision, which has coexisted with ERISA for decades. *See* Opp. 12-17. If the Department of Labor nonetheless concluded that the provision is too "'odd'" or inconsistent with ERISA policy, the Department could seek to regulate its use. It has not done so, however, despite closely regulating the procedures for resolving benefit claims. Where the Department has chosen not to act, the Court should not craft a wholesale rule invalidating or suspending the plan term—particularly in a case where the claimant failed to exercise due diligence and the provision's enforcement was perfectly reasonable.

ARGUMENT

I. A Reasonable Limitations Provision In An ERISA Plan Should Be Enforced As Written

This Court has long held that contractual limitations provisions are enforceable unless unreasonable or specifically prohibited by statute. *See Order of United Commercial Travelers of Am.* v. *Wolfe*, 331 U.S. 586, 608 (1947); *Riddlesbarger* v. *Hartford Insurance Co.*, 74 U.S. (7 Wall.) 386 (1868). That principle fits hand-in-glove with ERISA's "purpose to protect contractually defined benefits," *Massachusetts Mut. Life Ins. Co.* v. *Russell*, 473 U.S. 134, 148 (1985), and it dictates the proper analysis of this case. Ms. Heimeshoff has never contended, and could not contend, that the limitations provision in Hartford's Policy is facially unreasonable or left her with inadequate time to sue. The provision is therefore enforceable unless ERISA specifically prohibits it. But ERISA's text is silent on the subject. It does not supply a limitations period and does not prohibit parties from adopting one. And although the implementing regulations closely govern procedures for

resolving benefit claims—including exhaustion and timing requirements—they neither address nor preclude enforcement of the ubiquitous proof-of-loss limitations provision.

A. Contracting Parties May Agree To A Reasonable Limitations Period, And Such Provisions Are Enforceable Unless Specifically Prohibited

1. Statutes of limitations "encourage promptness in the bringing of actions" so that "the parties shall not suffer by loss of evidence from death or disappearance of witnesses, destruction of documents, or failure of memory." *Missouri, Kan., & Tex. Ry. Co.* v. *Harriman Bros.*, 227 U.S. 657, 672 (1913). By "assur[ing] fairness to defendants," *Burnett* v. *New York Cent. R.R. Co.*, 380 U.S. 424, 428 (1965), limitations periods also serve the "general interest of the public," 1 Corman, *Limitations of Actions* §1.1 (1991):

> Judicial efficiency is the reward when these statutes produce speedy and fair adjudication of the rights of the parties. Certainty and finality in the administration of affairs is promoted, and courts are relieved of the burden of trying stale claims when plaintiffs have 'slept' on their rights.

See also Gabelli v. *SEC*, 133 S. Ct. 1216, 1221 (2013); *United States* v. *Kubrick*, 444 U.S. 111, 117 (1979).

Consistent with these salutary purposes and with the freedom of contract, courts have long held that contracting parties may include a limitations provision in their agreement and that such provisions are enforceable unless unreasonable or specifically prohibited by statute. *Wolfe*, 331 U.S. at 608; *see also Leigh Ellis &*

Co. v. *Davis*, 260 U.S. 682, 688-689 (1923); *Thompson* v. *Phenix Ins. Co.*, 136 U.S. 287, 298 (1890); *Riddlesbarger*, 74 U.S. (7 Wall.) at 390. Parties adopting such provisions are not bound by the terms of the otherwise-applicable statute of limitations. The purpose of a statute of limitations is simply "'to encourage promptitude in the prosecution of remedies'" by establishing a deadline beyond which liability is cut off and the defendant may find repose. *Wolfe*, 331 U.S. at 608 n.20. Nothing in that purpose "'inhibits parties from stipulating for a shorter period within which to assert their respective claims.'" *Id.*

The right to "stipulat[e] for a shorter period" reflects the general freedom of contracting parties to agree to terms of their choosing. As this Court explained in enforcing an insurance policy term requiring suit to be commenced within 12 months after the loss, "[t]he contract of insurance is a voluntary one." *Riddlesbarger*, 74 U.S. (7 Wall.) at 390. Insurers therefore "have a right to designate the terms upon which they will be responsible for losses." *Id.* "It is clearly for the interest of insurance companies that the extent of losses sustained by them should be speedily ascertained, and it is equally for the interest of the assured that the loss should be speedily adjusted and paid." *Id.* Therefore, "it is not an unreasonable term" to require suit "whilst the transaction is recent, and the proofs respecting it are accessible." *Id.*; *see also Wolfe*, 331 U.S. at 599 (upholding insurance provision requiring suit within six months after claim is disallowed).

As the United States concedes (at 16-17), this freedom-of-contract principle applies as a matter of federal common law in suits to enforce federal statutory

rights.[8] This Court has invoked the principle, for example, to uphold a 90-day limitations provision in an interstate shipping contract in a suit under the Carmack Amendment to the Hepburn Act. *Harriman Bros.*, 227 U.S. at 672-673. The Court evaluated the validity of the limitations period as "a Federal question to be determined under the general common law," and enforced it because it was reasonable. *Id.* at 672; *see also Louisiana & W.R. Co.* v. *Gardiner*, 273 U.S. 280, 283 (1927); *Texas & Pac. Ry. Co.* v. *Leatherwood*, 250 U.S. 478, 481-482 (1919). Courts have applied the same principle to enforce contractual limitations provisions in a host of other federal contexts. *See, e.g.*, *Cange* v. *Stotler & Co.*, 826 F.2d 581, 583-584 (7th Cir. 1987) (Commodity Exchange Act); *Farris* v. *Celebrity Cruises, Inc.*, 487 F. App'x 542, 543-544 (11th Cir. 2012) (maritime suit); *Entous* v. *Viacom Int'l, Inc.*, 151 F. Supp. 2d 1150, 1155-1156 (C.D. Cal. 2001) (Copyright Act); *Reichhold Chems., Inc.* v. *United States*, 11 Cl. Ct. 150, 152-153 (1986) (government contract).

2. In "designat[ing] the terms upon which they will be responsible for losses," *Riddlesbarger*, 74 U.S. (7 Wall.) at 390, contracting parties may specify not only the length of the limitations period, but also its other features. For example, a contractual limitations provi-

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[8] The enforceability of the Policy's limitations provision under ERISA is a federal question. Ms. Heimeshoff claims (at 30) the court of appeals upheld the provision on the ground that "*state law* permitted alteration of accrual dates." But the court specifically acknowledged that "federal law controls" the issue. Pet. App. 3. And the precedent relied on by the court of appeals analyzed the provision in light of ERISA, *see Burke* v. *PriceWaterhouseCoopers LLP Long Term Disability Plan*, 572 F.3d 76, 80-81 (2d Cir. 2009) (per curiam), noting only in passing that state law independently allowed the provision, *id.* at 78-79.

sion may relieve the parties of exceptions found in the otherwise-applicable statute of limitations. *Id.* at 391; *see also Chichester* v. *New Hampshire Fire Ins. Co.*, 51 A. 545, 546-547 (Conn. 1902). Parties may alter the date on which a suit is considered filed for purposes of satisfying the limitations period. *See J. Aron & Co.* v. *The Askvin*, 267 F.2d 276, 277 (2d Cir. 1959) (per curiam). And in *Thompson*, this Court recognized the validity of a waiting-period provision in an insurance policy barring any suit before "60 days had elapsed after the receipt of the proofs of loss." 136 U.S. at 292.

It follows that just as parties can alter the length and other features of the limitations period, they can also choose the starting point from which the limitations period is measured. *See, e.g., International Union of Elec., Radio & Mach. Workers, Local 790* v. *Robbins & Myers, Inc.*, 429 U.S. 229, 234 (1976) ("parties could conceivably have agreed to a contract" making certain conduct the "relevant statutory 'occurrence'" triggering the start of the limitations period). For example, parties may contract to avoid application of the discovery rule, which would otherwise delay the running of the limitations period until a time when the plaintiff knew or should have known of the wrong. *Harbor Ct. Assocs.* v. *Leo A. Daly Co.*, 179 F.3d 147, 149 (4th Cir. 1999). Similarly, federal courts have applied limitations provisions in bills of lading running from the date "the loss occurred," *Leatherwood*, 250 U.S. at 479; "'delivery of the property,'" *Leigh Ellis & Co.*, 260 U.S. at 688; "the giving of written notice" of the loss, *Schnell* v. *United States*, 30 F.2d 676, 677 (2d Cir. 1929); *see also The Turret Crown*, 284 F. 439, 441 (4th Cir. 1922); and "written disallowance of a claim for loss," *North Am. Phillips Corp.* v. *Emery Air Freight Corp.*, 579 F.2d 229, 234 (2d Cir. 1978). And federal

courts have enforced insurance contract provisions requiring suit within twelve months from the date of "the loss," *Riddlesbarger*, 74 U.S. (7 Wall.) at 389; six months from "the date the claim ... is disallowed," *Wolfe*, 331 U.S. at 599; three years from the date "'written Proof of Loss is required to be furnished,'" *Matthew* v. *Unum Life Ins. Co. of Am.*, 639 F.3d 857, 866 (8th Cir. 2011); and two years from "'the date you were first sent a notice of the service or claim denial,'" *Island View Residential Treatment Ctr.* v. *Blue Cross Blue Shield of Mass., Inc.*, 548 F.3d 24, 27 (1st Cir. 2008).

Many insurance policies that include limitations provisions running from the time of the "loss" (or something close to it) also preclude suit until the insurer has decided the claim. *See, e.g.*, *Madi* v. *Modern Woodmen of Am.*, 167 P. 1083, 1084-1085 (Wash. 1917) (18-month limitation provision in life insurance certificate commenced upon "the date of the death," notwithstanding policy language precluding suit until insurer decided the claim); *Proc* v. *Home Ins. Co.*, 217 N.E.2d 136, 139 (N.Y. 1966) (12-month limitation provision in fire insurance policy ran "from the date of the fire, even though a cause of action against the insurer had not then accrued").[9] Referring to such a policy, this Court recognized in *Wolfe* that the parties' freedom to adopt a reasonable limitations provision permitted enforcement of "a clause in a fire insurance policy providing that no ac-

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[9] *See also, e.g.*, *Rottier* v. *German Ins. Co. of Freeport, Ill.*, 86 N.W. 888, 889 (Minn. 1901); *Simms* v. *Allstate Ins. Co.*, 621 P.2d 155, 156-157 (Wash. Ct. App. 1980); *Adams* v. *Northern Ins. Co. of N.Y.*, 493 P.2d 504, 507 (Ariz. Ct. App. 1972); 17 *Couch* § 236:30 (limitations period on life insurance claims "generally ... triggered by the death of the insured, not when the claim is rejected and the action accrues").

tion for recovery of any claim shall be sustainable in any court unless commenced within six months after the fire itself, even though such actions were prohibited during most of the first three of those months." 331 U.S. at 610.

Thus, as Ms. Heimeshoff concedes (at 12), policies commonly include a 60-day waiting period that must elapse before a policyholder may file suit. *See FDIC* v. *Hartford Accident & Indem. Co.*, 97 F.3d 1148, 1149-1151 (8th Cir. 1996). The waiting period allows the insurer time to decide whether to pay the claim and requires the claimant to submit proof of loss and await the insurer's decision while the limitations provision is running. *See, e.g.*, *Chambers* v. *Atlas Ins. Co.*, 51 Conn. 17, 1883 WL 1583, at *2 (1883) ("The contract keeps the day upon which a fire shall occur entirely distinct from the day upon which the right to sue for indemnity accrues[.]"); *Appel* v. *Cooper Ins. Co.*, 80 N.E. 955, 957-958 (Ohio 1907) (presentation of proof of loss and expiration of waiting period are conditions precedent to suit that must be completed within the limitations period); *Wever* v. *Pioneer Fire Ins. Co.*, 153 P. 1146, 1147-1149 (Okla. 1915) (same); *John Morrell & Co.* v. *New England Fire Ins. Co.*, 44 A. 358, 358-359 (Vt. 1899) (same). Like any other contractual limitations term, such provisions reflect the contracting insurer's "right to designate the terms upon which they will be" liable and are enforceable if reasonable and not specifically prohibited. *Riddlesbarger*, 74 U.S. (7 Wall.) at 390.

Ms. Heimeshoff has never contended that the time allowed under Hartford's Policy is "unreasonably short" on its face. *Harriman Bros.*, 227 U.S. at 672. Nor could she, given the provision's ubiquity and historical roots and the prevalence of equivalent or shorter limitations periods throughout the U.S. Code. *See*

Jerry § 85[a] ("Almost uniformly, courts have held contractual limitations periods as short as one year to be reasonable in length."). As the United States concedes, this reasonable provision is therefore enforceable "'in the absence of a controlling statute to the contrary.'" U.S. Br. 17 (quoting *Wolfe*, 331 U.S. at 608). The Court found such a controlling statute in *Gardiner*, where a bill of lading requiring suit within two years and one day after delivery was held invalid in the face of a federal statute "declar[ing] unlawful any limitation shorter than two years from the time notice is given of the disallowance of the claim." 273 U.S. at 284; *see also Leatherwood*, 250 U.S. at 480 n.1. Absent a similar command in ERISA, the reasonable limitations period in Hartford's Policy is enforceable.

B. ERISA Requires Enforcement Of Plan Terms Unless Prohibited

The principle that a reasonable contractual limitations provision should be enforced as written "fits lock and key with ERISA's focus on what a plan provides." *US Airways, Inc.* v. *McCutchen*, 133 S. Ct. 1537, 1548 (2013). ERISA protects "contractually defined benefits," *Russell*, 473 U.S. at 148, and incorporates freedom-of-contract concepts. As this Court has recognized, ERISA neither "'requires employers to establish employee benefit plans'" nor "'mandate[s]'" the benefits employers provide. *Black & Decker* v. *Nord*, 538 U.S. 822, 833 (2003); *see also Curtiss-Wright Corp.* v. *Schoonejongen*, 514 U.S. 73, 79 (1995). "Rather, employers have large leeway to design disability and other welfare plans as they see fit." *Black & Decker*, 538 U.S. at 833; *see also Rice* v. *Jefferson Pilot Fin. Ins. Co.*, 578 F.3d 450, 455 (6th Cir. 2009) ("We have specifically emphasized the freedom of parties to contract for the de-

tails of ERISA claims[.]"); *Northlake Reg'l Med. Ctr.* v. *Waffle House Sys. Emp. Benefit Plan*, 160 F.3d 1301, 1303 (11th Cir. 1998) ("An ERISA plan is nothing more than a contract, in which parties as a general rule are free to include whatever limitations they desire.").

Encouraging employers to offer welfare plans is one of ERISA's central goals. *See Aetna Health, Inc.* v. *Davila*, 542 U.S. 200, 215 (2004) (citing *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 55 (1987)); *see also Conkright* v. *Frommert*, 130 S. Ct. 1640, 1648-1649 (2010). To that end, "Congress sought 'to create a system that is [not] so complex that administrative costs, or litigation expenses, unduly discourage employers from offering [ERISA] plans in the first place.'" *Conkright*, 130 S. Ct. at 1649 (quoting *Varity Corp.* v. *Howe*, 516 U.S. 489, 497 (1996)). Rather, "ERISA 'induc[es] employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred." *Id.* (quoting *Rush Prudential HMO, Inc.* v. *Moran*, 536 U.S. 355, 379 (2002)).

ERISA delivers that predictability through the promise that a plan will be enforced as written. The statutory scheme "'is built around reliance on the face of written plan documents.'" *McCutchen*, 133 S. Ct. at 1548. It requires fiduciaries, claimants, and courts to "hew[] to" the contractual "plan documents" as written. *Kennedy* v. *Plan Adm'r for DuPont Sav. & Inv. Plan*, 555 U.S. 285, 300 (2009). "Every employee benefit plan shall be established and maintained pursuant to a written instrument," 29 U.S.C. § 1102(a)(1), and a fiduciary must act "in accordance with the documents and instruments governing the plan," so long as they are consistent with the statute and regulations, *id.*

§ 1104(a)(1)(D). Section 1132(a)(1)(B) thus authorizes suit to "recover benefits due ... *under the terms of* [*the*] *plan*, to enforce ... rights *under the terms of the plan*, or to clarify ... rights to future benefits *under the terms of the plan*." *Id.* § 1132(a)(1)(B) (emphases added). "The [written] plan, in short, is at the center of ERISA." *McCutchen*, 133 S. Ct. at 1548.

This Court has accordingly refused to rewrite or ignore plan terms to achieve policies or satisfy requirements that do not appear in ERISA's text or implementing regulations. As the United States has observed, "[i]t would be inconsistent with Congress's judgment generally eschewing regulation of the substantive content of ERISA plans" to give courts authority "not to enforce the terms of the plan as written." U.S. Br. 13, *US Airways* v. *McCutchen*, No. 11-1285 (U.S. Sept. 5, 2012). In *Kennedy*, for example, the Court refused to craft a "federal common law of waiver" for divorce decrees that waive a divorced spouse's benefits but fail to comply with the procedures outlined in the written plan. 555 U.S. at 303. Such a waiver "might obscure a plan administrator's duty to act 'in accordance with the [plan] documents and instruments.'" *Id.* (quoting *Mertens* v. *Hewitt Assocs.*, 508 U.S. 248, 259 (1993)). Similarly, in *Black & Decker*, the Court declined to subject a plan to a judicially crafted treating-physician rule where nothing in the statute or regulations required plan fiduciaries to defer to the opinions of treating physicians. 538 U.S. at 829-834. Reading such a requirement into the statute would have undermined ERISA's goal of allowing employers to "design ... plans as they see fit." *Id.* at 833.

Even in the equitable context of a Section 1132(a)(3) suit, this Court held in *McCutchen* that courts had no authority to deviate from the "clear

terms of a plan." 133 S. Ct. at 1543. The United States doubts *McCutchen*'s relevance (at 18 n.3) because it involved an action analogous to enforcement of an "equitable lien by agreement," but that reasoning is backwards: If anything, a suit for "benefits due ... under the terms of [the] plan," 29 U.S.C. § 1132(a)(1)(B), is *more* tightly constrained by the terms of the plan than a suit for equitable relief under Section 1132(a)(3). "The statutory language [of Section 1132(a)(1)(B)] speaks of '*enforc[ing]*' the 'terms of the plan,' not of *changing* them." *CIGNA Corp.* v. *Amara*, 131 S. Ct. 1866, 1876-1877 (2011).[10]

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[10] The United States (at 24-25) mentions trust law, but no trust-law principle justifies rewriting or ignoring the settlor's intentions as expressed in the trust documents. And even if it were correct to analogize a final denial of benefits to a trust beneficiary's receipt of an accounting revealing the existence of a claim—a dubious analogy—the argument would still be incorrect. A statute of limitations on a trust claim can begin to run before the beneficiary receives such an accounting. *See* Bogert et al., *The Law of Trusts and Trustees* § 969 (2012) (under Uniform Trust Code (UTC), action for breach of trust is barred five years after the first of several events "even if the trustee does not furnish such notice to a beneficiary"); *see also, e.g.*, Del. Code Ann. tit. 12, § 3585 (same in non-UTC jurisdiction).

Petitioner also cites (at 6) "higher-than-marketplace quality standards" requiring fiduciaries to "discharge [their] duties ... solely in the interests of the participants and beneficiaries of the plan." *Metropolitan Life Ins. Co.* v. *Glenn*, 554 U.S. 105 (2008). ERISA's fiduciary obligations, however, do not govern the creation of a plan or its terms. *Lockheed Corp.* v. *Spink*, 517 U.S. 882, 890 (1996). When those obligations do apply, the fiduciary "d[oes] its statutory ERISA duty" by acting "in conformity with the plan documents." *Kennedy*, 555 U.S. at 300; *see* 29 U.S.C. § 1104(a)(1)(D).

C. Nothing In ERISA's Text Or Regulations Prohibits Enforcement Of The Policy's Limitations Provision

Consistent with the foregoing principles, the reasonable contractual limitations provision at issue here must be enforced as written unless ERISA or its regulations specifically preclude it. They do not.

Although Congress enacted a statute of limitations to govern claims for breach of fiduciary duty, *see* 29 U.S.C. § 1113, it did not enact a statute of limitations for denial-of-benefits claims under Section 1132(a)(1)(B). As all agree, the statute is silent. Pet. Br. 9. It neither expressly prohibits a contractual limitations provision nor supplies any other limitations rule. ERISA's text requires only that a plan provide adequate notice of a denial decision and a full and fair administrative review, 29 U.S.C. § 1133, and that claimants be afforded access to federal courts to vindicate their rights, *id.* §§ 1001(b), 1132. None of these requirements addresses the limitations period applicable to such suits.

Regulations implementing ERISA likewise say nothing about the enforceability of a contractual limitations provision in a denial-of-benefits suit. *See* 29 C.F.R. § 2560.503-1. The regulations specify in great detail what an ERISA plan must do to provide a full and fair opportunity for review. Among other things, the regulations govern the amount of time a plan may take to resolve a claim initially and on appeal, *see id.* § 2560.503-1(f), (h), (i); provide for tolling of those time limits when necessary due to a "claimant's failure to submit information necessary to decide a claim," *id.* § 2560.503-1(f)(4); *see id.* § 2560.503-1(i)(4); and create exceptions to the exhaustion requirement in circum-

stances where the Department has found it necessary to adjust for any conflict between the internal review process and the availability of judicial review, *see id.* § 2560.503-1(c)(3)(i), (k)(2)(ii), (*l*). Among those exceptions, the regulations provide that if a plan misses the deadlines for resolving a claim or otherwise fails to comply with regulatory requirements, "the claimant shall be deemed to have exhausted" administrative remedies and "shall be entitled to pursue" judicial review under Section 1132(a)(1)(B). *Id.* § 2560.503-1(*l*). The regulations also provide that "any statute of limitations or other defense based on timeliness" shall be tolled during the pendency of a voluntary additional appeal where a plan offers one. *Id.* § 2560.503-1(c)(3)(ii).

The regulations thus address many details of claims processing, including the time limits and exhaustion requirements. Yet, despite the ubiquity of limitations provisions that run from the proof-of-loss deadline, the regulations are silent as to the enforceability of such a provision. Like the statute, the regulations do not supply any particular limitations provision, and they do not prohibit any contractual limitations provision.

ERISA's directive to adhere to plan terms and a century of common law recognizing the validity of reasonable contractual limitations provisions each require the Court to give effect to the Policy's reasonable limitations provision unless ERISA specifically prohibits it. Because the statute and regulations do not prohibit the provision, the limitations provision is enforceable as written and bars Ms. Heimeshoff's suit.

II. No Immutable Accrual Rule Invalidates The Policy's Limitations Provision

Lacking a textual basis for her position, Ms. Heimeshoff argues that ERISA silently incorporates a "rule" that the limitations period governing a federal statutory cause of action must run from the time a plaintiff's cause of action "accrues"—that is, when the plaintiff has a complete and present cause of action. Pet. Br. 21-29; *see also* U.S. Br. 13-16. But that "rule" merely reflects a general approach to identifying the time of accrual when a statute of limitations expressly runs from the time a cause of action "'accrues.'" *Bay Area Laundry & Dry Cleaning Pension Trust Fund* v. *Ferbar Corp. of Cal., Inc.*, 522 U.S. 192, 201 (1997). It is a default rule of statutory interpretation that recognizes that Congress usually (but not always) writes statutes that measure the limitations period from the date the cause of action "accrues" and that such language usually (but not always) refers to the date the plaintiff can file suit and obtain relief. The rule does not dictate that all statutes of limitation must be written that way, it does not apply when the limitations provision starts the period running at a time other than "accrual," and it says nothing about contracting parties' authority to agree to a limitations provision that measures the time for filing suit from a point of their choosing.

The scope of the rule is evident from the decisions of this Court Ms. Heimeshoff cites. Nearly all required the Court to interpret and apply a statutory limitations provision that ran from the date the claim "accrued." In *Gabelli*, 133 S. Ct. at 1219, for example, the statute required suit to be commenced within "'five years from the date when the claim first accrued.'" Reasoning that "accrual" normally refers to the time "'when the plaintiff has a complete and present cause of action,'" the

Court held that Congress intended the limitations period to begin at the time a fraud occurs, rather than later, upon discovery of the fraud. *Id.* at 1220. Thus, the statute of limitations ran from the time the cause of action "accrued" because Congress said so, and the Court applied the default rule to determine when that accrual occurred.

The other cases are to the same effect. In each, the Court looked to the date the cause of action arose as the trigger for starting the limitations period because the statute expressly said the period ran from the cause of action's "accrual." And in each case, the Court applied the "ordinarily applicable" rule that a statutory reference to "accrual" means the time when a plaintiff has a complete and present cause of action on which he can file suit and obtain relief. *Bay Area Laundry*, 522 U.S. at 195, 197 (applying limitations period tied to "date on which the cause of action arose" (citing *Rawlings* v. *Ray*, 312 U.S. 96, 98 (1941))); *see Wallace* v. *Kato*, 549 U.S. 384, 387 (2007) (borrowing Illinois statute running from "accru[al]" of cause of action, 735 Ill. Comp. Stat. Ann. 5/13-202 (West 2003)); *Crown Coat Front Co.* v. *United States*, 386 U.S. 503, 514 (1967) (applying statute tied to date "the right of action first accrues"); *Spannaus* v. *DOJ*, 824 F.2d 52, 55 (D.C. Cir. 1987) (applying statute requiring suit "'within six years after the right of action first accrues'").

Indeed, in *Reiter* v. *Cooper*, 507 U.S. 258, 263 (1993), the statute of limitations specified not only that the period ran "'within two years after the claim accrues,'" but also that accrual "occur[red] 'on delivery or tender of delivery by the carrier.'" The Court thus recognized that because Congress had specified the accrual date, it would be "odd" to conclude the claim had not ripened as of that date. *Id.* at 267. Similarly, in *Clark*

v. *Iowa City*, 87 U.S. (20 Wall.) 583, 589 (1875), the Court interpreted an Iowa statute requiring suit to be filed within ten years "after the[] cause[] accrue[d]," Iowa Code § 2740.4 (1872), and it cited the general accrual rule to reject the argument that the statute of limitations could "sleep[]" even *after* "a complete right of action ... exists in the holder."[11]

In the decisions of this Court Ms. Heimeshoff cites that did not involve a statute of limitations running from the date of accrual, the Court simply relied on the "default rule" to interpret an ambiguous statutory limitations provision. *See Graham County Soil & Water Conservation Dist.* v. *United States ex rel. Wilson*, 545 U.S. 409, 418 (2005). Between two plausible constructions, the Court adopted the one "that start[ed] the time limit running when the cause of action ... accrues." *Id.* at 419.[12]

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[11] Ms. Heimeshoff cites (at 22-23) administrative schemes in which the period for filing suit is tied to the final decision concluding a mandatory pre-suit process. *See, e.g., Bowen* v. *City of N.Y.*, 476 U.S. 467 (1986). All these schemes show is that there is more than one way to draft a limitations period. As in *Bowen*, time limits are sometimes written to provide a guaranteed—usually very short—window of opportunity for a claimant to proceed from one step of review to the next. Other limitations provisions serve not to grant claimants a minimum number of days within which to sue, but to cut off liability at an ascertainable deadline by which all prelitigation steps must be completed and suit must be filed. *See, e.g., McMahon* v. *United States*, 342 U.S. 25, 27 (1951); *Wolfe*, 331 U.S. at 610; *Proc*, 17 N.Y.2d at 242-245. Nothing in ERISA or the general law of limitations compels the use of one formulation over the other.

[12] Similarly, the limitations period applicable to "hybrid" suits under Section 301 of the Labor Management Relations Act—borrowed from Section 10(b) of the National Labor Relations

These decisions thus stand for the proposition that when a statute of limitations measures the time for filing suit from the date a cause of action "accrues" (or is ambiguous as to the operation of the limitations period), courts interpret the statutory language to mean that the period begins to run when the plaintiff has a complete and present cause of action. *See TRW Inc.* v. *Andrews*, 534 U.S. 19, 36-37 (2001) (Scalia, J., concurring in judgment) (federal statute "which says the [limitations] period runs from 'the date on which the cause of action arose'" should be read in light of background rule that limitations periods "begin[] to run at the time the plaintiff 'has the right to apply to the court for relief,'" not when the plaintiff later discovers the injury).[13]

Moreover, that rule of statutory interpretation is only a "default," *Graham County*, 545 U.S. at 418: Where the legislature clearly indicates that the limitations period runs from a time other than the cause of action's accrual, the standard rule does not apply. *Crown Coat Front*, 386 U.S. at 514; *see Gabelli*, 133 S. Ct. at 1224 (rule applies absent contrary "mandate from

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Act—is ambiguous as to its start date when applied in the hybrid-suit context. *See DelCostello* v. *International Bhd. of Teamsters*, 462 U.S. 151, 155 (1983); 29 U.S.C. § 160(b) (period starts when unfair labor practice "occur[s]"). As in *Graham County*, the circuit court cases Ms. Heimeshoff cites (at 25 n.7) follow the default approach to resolve that ambiguity.

[13] *See also* 1 Corman § 6.1 ("Frequently, legislation stating that commencement occurs when the plaintiff's cause of action accrues is interpreted by courts to mean that moment when the plaintiff has a complete and present cause of action."); 1 Wood, *A Treatise on the Limitation of Actions At Law and in Equity* § 117 (4th ed. 1916) ("By the express terms of all the statutes, the statute of limitations only begins to run from the time when the right of action accrues[.]").

Congress"); *Bay Area Laundry*, 522 U.S. at 201 (same); *Reiter*, 507 U.S. at 267 (same); *Graham County*, 544 U.S. at 419 n.2 ("We apply the rule that Congress generally drafts statutes of limitations to begin when the cause of action accrues to resolve [an] ambiguity, not to create it in the first instance.").

In *Dodd* v. *United States*, 545 U.S. 353 (2005), for example, this Court considered the limitations provision of the federal habeas statute, which tied the start of the limitations period not to the accrual of the cause of action, but instead to a series of other events. The "standard rule that the limitations period commences when the plaintiff has a complete and present cause of action" therefore had no bearing. *Id.* at 360 (internal quotation marks omitted). Rather, the "only natural reading" of the limitations provision was one in which the period began to run *before* some applicants could petition for relief. *Id.* at 358-359.

A different rule also applied in *McMahon* v. *United States*, 342 U.S. 25, 27 (1951), where the Court construed the limitations period in the Suits in Admiralty Act "to be computed from the date of the injury," not when the plaintiff's claim was disallowed through a mandatory administrative process. The Court acknowledged the plaintiff's contention that "the period of limitations c[ould] not start to run until his claim ha[d] been administratively disallowed because only then does his 'cause of action' arise." *Id.* at 26-27. But the Court rejected that argument based on the statute's text and history. *Id.* at 27. The purpose of the administrative process in that case was to allow an opportunity to resolve the dispute without litigation, not to give the plaintiff the "power, by delaying its filing, to

postpone indefinitely commencement of the running of the statute of limitations." *Id.*[14]

The rule upon which Ms. Heimeshoff relies is thus doubly inapplicable. First, the limitations provision here, like the one in *Dodd*, "clearly specifies the date on which the limitation period begins to run," 545 U.S. at 360, and it sets that date at a time other than the cause of action's "accrual." A default rule defining when a cause of action "accrues" therefore does not determine when the period begins to run.

Second, this case concerns a *contractual* limitations provision. As discussed, *supra* Part I.A, parties are free when entering into a voluntary agreement to adopt a limitations provision by contract, so long as the provision is reasonable and not specifically prohibited by statute. None of the cases cited by Ms. Heimeshoff or the United States involves a contractual limitations provision. They reflect only a rule developed to discern legislative intent, which does not limit the terms private contracting parties may adopt. Moreover, none of the cases hints—contrary to more than a century of case law, *see supra* Part I.A—that statutory *silence* can prohibit the enforcement of a reasonable contractual limitations provision.

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[14] The Court in *McMahon* also noted that if the plaintiff's claim was not administratively disallowed within a specified time, the claim would be presumed denied, and the plaintiff would be free to sue. *See* 342 U.S. at 28. The same is true here. *See* 29 C.F.R. § 2560.503-1(*l*).

III. ERISA'S REMEDIAL SCHEME DOES NOT IMPLICITLY PROHIBIT THE LIMITATIONS PROVISION

The absence in ERISA's text and regulations of any prohibition against the Policy's limitations provision ought to end the matter. Ms. Heimeshoff argues, however, that ERISA's remedial "scheme" and "purposes" implicitly preclude the provision's enforcement.

Notably, her argument is not that ERISA requires claimants to have more time to sue than she had here. Ms. Heimeshoff does not dispute—and the United States all but concedes (at 23 n.4)—that a one-year limitations period running from the final adverse decision would be enforceable. That hypothetical provision would have given Ms. Heimeshoff *less* time to sue than Hartford's Policy allowed in this case. Ms. Heimeshoff nonetheless contends that, by measuring the time for filing suit from a date that precedes the accrual of a cause of action, Hartford's longer limitations provision undermines ERISA's remedial regime because its enforcement *theoretically* could limit a claimant's access to judicial review or impede the administrative appeal in rare cases. This speculation is baseless and cannot justify judicial revision of the plan.

A. Perceived Inconsistency With One Of ERISA's Competing Purposes Is Insufficient To Invalidate A Plan Term

As an initial matter, "vague notions" about ERISA's "'basic purpose'" are by themselves an "inadequate" basis to override a plan's written terms. *Mertens*, 508 U.S. at 261-262. ERISA is an "enormously complex and detailed" statute "that resolved innumerable disputes between powerful competing interests—not all in favor of potential plaintiffs." *Id.* at 262. It does not have one overriding purpose. The Act's

"principal function" is not to achieve a free-floating remedial goal (at the expense of encouraging plan formation), but "to 'protect contractually defined benefits'" embodied in the written plan. *McCutchen*, 133 S. Ct. at 1548.

Given this "'careful balance[e],'" *Davila*, 542 U.S. at 215, this Court has refused to read into ERISA requirements, remedies, or prohibitions that do not appear in its text, even where doing so would purportedly advance a remedial aim. In *Guidry* v. *Sheet Metal Workers National Pension Fund*, 493 U.S. 365, 376 (1990), for example, the Court found it "[in]appropriate to approve any generalized equitable exception" to ERISA's anti-assignment provision, even to remedy "employee malfeasance or ... criminal misconduct." The anti-assignment provision "reflect[ed] a considered congressional policy choice," and "[i]f exceptions to this policy [we]re to be made, it [would be] for Congress to undertake that task." *Id.*

The Court has similarly "emphasized [its] unwillingness to infer causes of action in the ERISA context, since th[e] statute's carefully crafted and detailed enforcement scheme provides 'strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly.'" *Mertens*, 508 U.S. at 254 (quoting *Russell*, 473 U.S. at 146-147); *see also Pilot Life*, 481 U.S. at 54 (declining to "undermine[]" ERISA's balance of policy choices by permitting claimants to pursue remedies Congress rejected).

Similarly, even given ERISA's "expansive" preemptive scope, *Davila*, 542 U.S. at 208, the Court has held that speculative conflicts with ERISA's remedial "scheme" do not warrant preemption of state insurance laws mandating policy terms, *see, e.g.*, *Rush*

Prudential, 536 U.S. at 375-385; *UNUM Life Ins. Co. of Am.* v. *Ward*, 526 U.S. 358, 375-378 (1999). That is true even where the impact of those laws on claims procedures "could mean the difference between success and failure for a beneficiary." *Rush Prudential*, 536 U.S. at 380. Only those state insurance laws purporting to provide "additional claim[s] or remed[ies]" have been found so incompatible with ERISA's remedial scheme as to frustrate congressional intent. *Id.* And that conclusion rested on numerous clues as to Congress's preemptive intent in ERISA's text, structure, and legislative history. *Id.* at 377-381. Absent comparably clear evidence, this Court has observed that "further limits on [state] insurance regulation" based on a perceived conflict with ERISA's remedial scheme "are unlikely to deserve recognition." *Id.* at 381.[15]

Thus, a perceived conflict with ERISA's general remedial aims—even if it had any basis in fact—would be an insufficient basis to read into the statute a prohibition that does not appear there or to invalidate a plan term based on that implied prohibition. To the contrary, a plan term may be invalidated only to the degree that it specifically conflicts with an express term of the

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[15] The United States is thus wrong to assume (at 28 n.5) that ERISA "likely" preempts the many state laws that require insurance policies to include a limitations provision like Hartford's. *See UNUM Life Ins.*, 526 U.S. at 374-377 (state laws mandating insurance contract terms "regulate[] insurance" and thus fall within ERISA's saving clause absent the kind of conflict discussed above); *see also Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724, 758 (1985).

statute or its implementing regulations. *See Black & Decker*, 538 U.S. at 829-834; *supra* Part I.B.[16]

B. Enforcing Contractual Limitations Provisions Promotes Plan Formation

Ms. Heimeshoff's purposive argument also fails because enforcing a reasonable limitations provision in an ERISA plan actually promotes many beneficial goals of the statute. As explained, *see supra* Part I.B, adherence to the "directives of the plan documents," *Kennedy*, 555 U.S. at 300, "promotes [the] predictability" that induces employers to offer plans in the first place, *Conkright*, 130 S. Ct. at 1649. That is particularly so when the term is one that allows the plan to protect itself from the surprise of untimely and stale litigation.

Including a limitations provision in the plan avoids the uncertainty and disuniformity that could result if ERISA claims were subject to the state statutes of limitations that courts might otherwise borrow. As Ms. Heimeshoff observes (at 9), state statutes of limitations for breach-of-contract actions vary widely, "rang[ing] from three to fifteen years." And claimants have flexi-

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[16] The United States submits (at 17-18) that a plan provision "purporting to exempt the plan administrator from liability for suits" under Section 1132(a)(1)(B) "would be void." That is true, of course, but the reason is not because the term would be inconsistent with ERISA's free-floating remedial spirit, but because the text of the statute specifically provides for such liability and prohibits contrary terms. *See* 29 U.S.C. §§ 1110(a), 1132(a)(1)(B). Nor does a contractual limitations period "oust the courts of jurisdiction by excluding the assured from all resort to them for his remedy." *Riddlesbarger*, 74 U.S. (7 Wall.) at 391; *cf.* U.S. Br. 18. Rather, a limitations period "simply exacts promptitude on the part of the assured in the prosecution of his legal remedies." *Riddlesbarger*, 74 U.S. (7 Wall.) at 391.

bility about where to sue and thus what limitations provision to invoke. Without a contractual limitations provision, an insurer could not easily predict what limitations period will apply, making it more difficult to estimate the timing and volume of claims. A contractual provision provides the predictability and uniformity ERISA is meant to promote. *See Conkright*, 130 S. Ct. at 1649.

In contrast, a judicial decision categorically invalidating a plan's written limitations provision based on a perceived conflict with general ERISA policy would thwart ERISA's purposes. Employers and insurers justifiably rely on plan terms, including the limitations provisions required by state law. Wholesale invalidation of that mandatory term would upend that reliance interest and create significant uncertainty about the governing limitations period: May a court "blue-pencil" an ERISA plan so that the three-year limit in the plan continues to apply, but runs from the final denial? *See Belrose* v. *Hartford Life & Accident Ins. Co.*, 478 F. App'x 21, 23-24 (4th Cir. 2012). Or is the entire provision unenforceable such that the court should borrow an analogous state statute of limitations? *See Gillespie* v. *CUNA Mut. Group Long Term Disability Ins. Policy*, 2010 WL 1050286, at *3-4 (S.D. W. Va. Mar. 18, 2010); *compare* Pet. C.A. Br. 10 (arguing that Connecticut's six-year statute of limitations must apply), *with id.* 37 (positing that "the policy's limitations period could apply" if it ran from denial of the administrative appeal). And how do insurers comply with state laws mandating use of the provision?

Invalidation of the proof-of-loss provision in favor of a rule running the limitations period from exhaustion of administrative remedies also raises the question of when exhaustion occurs. *See Wetzel* v. *Lou Ehlers Ca-*

dillac Group Long Term Disability Ins. Program, 222 F.3d 643, 649 (2000) (denial-of-benefits claim accrues either upon actual denial or when claimant has reason to know of denial); *Fenwick* v. *Merrill Lynch & Co.*, 570 F. Supp. 2d 366, 371 (D. Conn. 2008) (under discovery rule, limitations period can run before final denial when claimant knows of clear repudiation). Similarly, when would the limitations period begin to run if a claimant is excused from exhausting administrative remedies? *See, e.g.*, *Hill* v. *Blue Cross & Blue Shield of Mich.*, 409 F.3d 710, 718-719 (6th Cir. 2005) (futility exception); *Smith* v. *Blue Cross & Blue Shield United of Wis.*, 959 F.2d 655, 659 (7th Cir. 1992) (exception when claimant "lack[s] ... meaningful access" to review procedures). And when does the period run if a claimant is "deemed to have exhausted" administrative remedies and entitled to pursue judicial review based on the plan's failure to follow regulatory requirements? *See* 29 C.F.R. § 2560.503-1(*l*); *see also Spannaus*, 824 F.2d at 59 (statute of limitations running from conclusion of mandatory administrative process runs from point the claim is deemed denied by operation of law, not final agency decision).

Enforcing the Policy's clear requirement that a suit challenging a denial of benefits must be brought within three years after the deadline for proof of loss avoids these questions. Far from violating ERISA's animating policy concerns, it respects the parties' expectations that the "directives of the plan documents" will be followed. *Kennedy*, 555 U.S. at 300.

C. The Limitations Provision Does Not Undermine ERISA's Remedial Scheme

Contrary to Ms. Heimeshoff's speculation, it is highly unlikely if not impossible that the Policy's limita-

tions provision would actually prejudice a diligent claimant. The provision allows more than enough time to complete a thorough administrative review and file suit if need be. Ms. Heimeshoff thus fails to cite a single example in which a diligent claimant was stymied by the limitations provision from vindicating her rights under the statute. Nor does she cite any other evidence that this ubiquitous limitations provision undercuts ERISA's remedial scheme in any way that cannot be addressed through the tools courts have always applied to statutes of limitations.

1. The limitations provision will virtually never disrupt the internal review or leave a claimant insufficient time to sue

a. Regulations strictly limit the time a plan may take to resolve a claim. In disability cases, the plan must make an initial decision within 45 days, with two 30-day extensions permitted when "necessary due to matters beyond the [plan's] control." 29 C.F.R. § 2560.503-1(f)(3). The claimant has up to 180 days to appeal, *id.* § 2560.503-1(h)(3)(i), (h)(4), and the plan must decide the appeal within 45 days, *id.* § 2560.503-1(i)(3)(i), with one 45-day extension permitted, *id.* § (i)(1)(i), (i)(3)(i). While variation occurs, the baseline schedule for exhausting internal review is thus, at most, 375 days.[17]

A plan that misses these deadlines is unlikely to succeed in blocking a claimant's access to judicial re-

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[17] State laws may further restrict the time an insurer can take to decide a claim. *See, e.g.*, Cal. Ins. Code § 10111.2; *see also* 29 C.F.R. § 2560.503-1(k) (state claims-processing rules not preempted).

view even if it wanted to and can face significant penalties for trying. As noted, if the plan fails to comply with the deadlines or other regulatory requirements, "the claimant shall be deemed to have exhausted" administrative remedies and "shall be entitled to pursue any available remedies" under Section 1132(a). 29 C.F.R. § 2560.503-1(*l*). If that "deemed-denied" provision is invoked, the plan risks losing the deferential standard of review that would otherwise apply to its benefits determination. *See* 63 Fed. Reg. 48,390, 48,397 (Sept. 9, 1998) (arguing for de novo review in deemed-denied cases).[18] Moreover, a plan's consistent failure to meet the regulatory deadlines could be deemed a violation of Section 1133's "full and fair review" requirement.

The regulations create far greater opportunity for the *claimant* to delay resolution of the administrative appeal. Ms. Heimeshoff notes (at 8, 42) that if a plan requests more information, the regulatory deadlines may be tolled until the claimant responds. *See* 29 C.F.R. § 2560.503-1(f)(4), (i)(4). Such tolling is permitted, however, only where the deadline is extended "due to a claimant's failure to submit information necessary to decide a claim." *Id.* If the claimant acts promptly, this will not draw out the claims process. *See* 65 Fed. Reg. 70,246, 70,250 (Nov. 21, 2000) (tolling available "if the reason for taking the extension" is claimant's failure to provide information). The Department of Labor

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[18] *See, e.g., Rasenack ex rel. Tribolet* v. *AIG Life Ins. Co.*, 585 F.3d 1311, 1315-1318 (10th Cir. 2009) (applying de novo review); *Nichols* v. *Prudential Ins. Co. of Am.*, 406 F.3d 98, 109-110 (2d Cir. 2005) (same); *but see Southern Farm Bureau Life Ins. Co.* v. *Moore*, 993 F.2d 98, 101 (5th Cir. 1993) (applying deferential review).

thus promulgated this tolling provision only after concluding that "providing a limited extension opportunity" would afford plans the "flexibility necessary to handle all claims appropriately" *without* sacrificing "prompt decisionmaking." *Id.* at 70,249, 70,250.[19]

Accordingly, even assuming the internal process takes the full amount of time permitted (or even longer if the claimant extends it), the limitations provision will virtually never leave a claimant without ample time to sue. If the deadlines are strictly observed, a claimant will have about two years in which to sue after a final appeal denial. And even in a protracted case like this one, where Hartford granted Ms. Heimeshoff's multiple requests for extensions of time to submit information in support of her claim and appeal, she still had more than a year remaining on the limitations period once the administrative process concluded. Indeed, the most extreme hypothetical Ms. Heimeshoff's amici can devise, which posits a claim and appeal taking upwards of 21 months, would still leave more than a year to sue. *See* United Policyholders Br. 4-8.

Any of these scenarios leaves claimants more than enough time to prepare and file a denial-of-benefits

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[19] Here, for example, although Ms. Heimeshoff asserts (at 42-43) that Hartford made "multiple requests at different intervals," the record shows that Hartford's requests were for one thing: a report from Ms. Heimeshoff's rheumatologist concerning her functionality and capacity to perform sedentary work. *Supra* pp. 7-8. Hartford had to ask "multiple" times only because it wanted to consider her claim on a complete record and its previous requests had gone unanswered. In a case where a plan did make multiple demands for new proof of loss, such demands potentially could be construed to establish a new proof-of-loss deadline for purposes of the limitations provision, depending on the circumstances.

suit. Such a suit is "a review proceeding, not an evidentiary proceeding." *Doe* v. *Blue Cross & Blue Shield United of Wis.*, 112 F.3d 869, 875 (7th Cir. 1997). The claimant will have already developed evidence of her disability through the claims process, and the record in court generally will be limited to that administrative record. *See, e.g.*, *Fleisher* v. *Standard Ins. Co.*, 679 F.3d 116, 121 (3d Cir. 2012); *Evans* v. *UnumProvident Corp.*, 434 F.3d 866, 876 (6th Cir. 2006). Here, for example, Ms. Heimeshoff's complaint alleged no facts outside the administrative record. JA60-83. The Section 1132(a)(1)(B) proceeding is thus "the equivalent of a suit to set aside an administrative decision," which often must be initiated within 30 or 60 days—a fraction of the time the Policy allows. *Doe*, 112 F.3d at 875.

If, in an exceptional case, a claimant runs out of time because the insurer delays the processing of the claim, fails to disclose relevant information, or misleads the claimant, a court may ameliorate any prejudice by applying estoppel or waiver. *See Thompson*, 136 U.S. at 298-299 ("If ... the failure of the plaintiff to sue within the time prescribed by the policy, computing the time from the date of the fire, was due to the conduct of the company, it cannot avail itself of the limitation[.]"); *FDIC* v. *Hartford Accident & Indem.*, 97 F.3d at 1151-1152; Jerry § 85[b]; 17 *Couch* §§ 237:76, 238:3, 238:20-81 (2005). And where a diligent claimant is prevented from suing on time by circumstances beyond her control or the insurer's failure to provide adequate notice, equitable tolling may apply. *See, e.g.*, *Irwin* v. *Department of Veterans Affairs*, 498 U.S. 89, 95 (1990) ("Time requirements in lawsuits between private litigants are customarily subject to 'equitable tolling.'"); *see also Veltri* v. *Building Serv. 32B-J Pension Fund*, 393 F.3d 318, 322-323 (2d Cir. 2004); *Ortega Candelaria* v. *Or-*

thobiologics LLC, 661 F.3d 675, 679-681 (1st Cir. 2011); 16 *Couch* § 235:82-83.

b. Contractual limitations provisions requiring suit to be commenced within three years after the proof-of-loss deadline have been in widespread use throughout ERISA's lifetime. *See supra* pp. 4-6. If these provisions regularly frustrated ERISA's remedial scheme, evidence of that ought to be readily available. Yet Ms. Heimeshoff cites no evidence that these provisions actually undercut claimants' access to court or the efficacy of the internal review process.[20]

To the contrary, Ms. Heimeshoff concedes that the internal review system works: Out of hundreds of thousands of benefit claims filed annually, only a small fraction end up in court. Pet. Br. 9. In part, that statistic reflects the fact that "insurers approve the vast majority of claims they receive." ACLI, *Private Long-Term Disability Income Insurance* 2 (2010). According to one 2008 study, group disability insurers approved 78.8 percent of submitted claims. *Id.* Of claims that were not approved, 25 percent were denied because the claimant recovered before expiration of the Elimination Period. *Id.* And when claims are denied and judicial review follows, timeliness is rarely an issue.

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[20] Ms. Heimeshoff claims (at 26) the limitations provision could lead to absurd results in a benefits-termination case, but her assertion is unfounded. Termination presents a different situation, and the limitations provision does not necessarily operate the same way as in an initial claims decision. When a plan asks a claimant who has been receiving benefits to submit new proof of loss substantiating her continued disability, that request would set a new deadline for proof of loss, triggering a fresh limitations period. *See, e.g.*, *Rotondi* v. *Hartford Life & Accident Ins. Co.*, 2010 WL 3720830, at *8 (S.D.N.Y. Sept. 22, 2010).

Thus, because even a lengthy administrative review process would still leave ample time to sue, it is implausible that plans or claimants would face any incentive to sacrifice the benefits of the internal review process. Claimants have good reason to present the strongest, most well-documented claim possible to the plan, both to maximize the chance of obtaining benefits without litigation and to create a favorable record for judicial review. A claimant is not going to short-change her own claim just so she will have 20 months to sue instead of 18. And for plans, engaging in "meaningful dialogue" through the internal review process helps avoid costly litigation. To the extent a claimant's desire to get paid as soon as possible or a plan's desire for finality creates any countervailing temptation to "cut short exchanges" in the administrative appeal (U.S. Br. 22), those incentives exist independently of any limitations period. The Policy's limitations provision cannot make more than a marginal difference in this existing mix of incentives.

Finally, if this ubiquitous limitations provision actually interfered with ERISA's remedial scheme in real cases, one would have expected the Department of Labor to address the problem in its claims-processing regulation or by proposing legislation to address it. In enacting the current regulation, the Department received comments on the time taken to process claims. 65 Fed. Reg. at 70,249. And it concluded that the deadlines it adopted would ensure both "timely benefit determinations" and a reasonable opportunity for "full and fair review of denied claims." *Id.* at 70,246; *see also id.* at 70,249-70,250; 63 Fed. Reg. 48,393 & n.10, 48,394. The Department also created regulatory exceptions to the exhaustion requirement and precluded assertion of the statute of limitations in particular circumstances in

which it found that an extended internal review process could delay access to court. *See* 29 C.F.R. § 2560.503-1(c)(3)(i), (c)(3)(ii), (k)(2)(ii), (*l*). Yet the Department evidently saw no need for any action regarding the proof-of-loss limitations provision. That inaction, amid such close scrutiny of the claims process, speaks volumes.

2. Enforcing a contractual limitations provision where "reasonable" is workable, certain, and faithful to plan terms

As discussed, *supra* Part I.A, this Court has long directed that contractual limitations provisions should be enforced so long as the period is not "unreasonably short." *Harriman Bros.*, 227 U.S. at 672. Ms. Heimeshoff predicts (at 43-48) that this familiar principle—and the prospect of tolling in exceptional cases—will result in a flood of "satellite litigation" and uncertainty as courts decide, willy-nilly, whether to enforce the terms of the plan. That caricature provides no basis to invalidate the limitations provision.

Courts have applied the reasonableness standard to contractual limitations provisions without difficulty for over a century. *See, e.g.*, *Riddlesbarger*, 74 U.S. (7 Wall.) at 390; *supra* Part I.A. Reasonableness is ordinarily a straightforward question that can be addressed with an economy of analysis by looking at the provision on its face. *See, e.g.*, *Leigh Ellis*, 260 U.S. at 689 ("The time allowed was reasonable."); *Leatherwood*, 250 U.S. at 481 ("The provision ... not being unreasonable, was valid[.]" (citation omitted)); *Harriman Bros.*, 227 U.S. at 673 ("The provision requiring suit to be brought within [90] days is not unreasonable."). The three-year provision here is facially reasonable. And claimants whose cases go to court rarely have trouble filing suit

within that period. The flood of litigation Ms. Heimeshoff warns of is thus, at most, a trickle.

Where any deeper case-specific treatment is appropriate, the lower courts have had no difficulty developing tests to assess the reasonableness of limitations periods in commercial contracts, ERISA plans, and insurance policies. *Compare, e.g., Doe*, 112 F.3d at 875 (ERISA plan provision reasonable), *and Davidson* v. *Wal-Mart Assocs. Health & Welfare Plan*, 305 F. Supp. 2d 1059, 1070, 1075 (S.D. Iowa 2004) (same), *with Henning Nelson Constr. Co.* v. *Fireman's Fund Am. Life Ins. Co.*, 383 N.W.2d 645, 651 (Minn. 1986) (insurance policy provision unenforceable where insurer did not deny claim until after expiration), *and Brown & Guenther* v. *North Queensview Homes, Inc.*, 18 A.D.2d 327, 329-331 (N.Y. App. Div. 1963) (limitations provision in commercial contract unreasonable "in the light of the facts presented").[21]

Ms. Heimeshoff objects (at 44-45) that an employee cannot examine Hartford's Policy and know *ex ante* what limitations provision would be enforced in a given case. But the Policy states unambiguously that suit must be brought within three years after proof of loss is due. A claimant seeking to "evaluate her potential rights" (Pet. Br. 45) should conclude that suit must be filed before that time expires. The fact that enforcement of the limitations period might be tolled or waived or precluded based on the facts of a particular case does not offend ERISA or cloud the plan's meaning. ERISA requires a written plan that informs employees of their "rights and obligations," *Curtiss-Wright*, 514 U.S. at 83;

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[21] *See also, e.g., Thurman* v. *DaimlerChrysler, Inc.*, 397 F.3d 352, 357-359 (6th Cir. 2004).

it does not require the clairvoyance to know how those rights and obligations will apply in all circumstances. A plan term providing that benefits are payable upon "total disability" is not invalid merely because it sets a standard that must be applied to facts. *Cf. Metropolitan Life Ins. Co.* v. *Glenn*, 554 U.S. 105, 117 (2008) (courts "review[ing] the lawfulness of benefit denials" often "tak[e] account of several different, often case-specific, factors").

Moreover, the "uncertainty" Ms. Heimeshoff perceives in the requirement that contractual limitations provisions be "reasonable" characterizes *all* statutes of limitations. Ms. Heimeshoff concedes (at 32-33) that state equitable tolling rules would apply in an ERISA case governed by a state statute of limitations. In such a case, "[n]o one could be sure" *ex ante* whether the statute of limitations would be enforced or tolled. Pet. Br. 45. If ERISA did not tolerate that "uncertainty," no limitations period could ever apply.

In any event, as discussed, Ms. Heimeshoff's position entails numerous uncertainties of its own, most of which are far more difficult to resolve. *Supra* pp. 38-39. Nor is her position unburdened by line-drawing (*cf.* Pet. Br. 45): Would a provision requiring suit to be filed within *ten* years after proof of loss is due be enforceable? It would be absurd to say no. Yet, if such a provision is enforceable, then the question presented here comes down to whether the length of the limitations period allows a reasonable time to complete a meaningful administrative review and file suit—an inquiry that confirms the validity of the provision at issue.

Nor does *enforcing* the contractual limitations provision as written, subject to reasonableness and tradi-

tional equitable principles, violate ERISA's mandate to adhere to the written plan. *Cf.* Pet. Br. 43-48. As this Court explained in *McCutchen*, courts applying an ERISA plan "properly take[] account of background legal rules ... that typically or traditionally have governed a given situation when no agreement states otherwise." 133 S. Ct. at 1549. Where a plan does not address an issue, such background rules give "the best indication of the parties' intent." *Id.* at 1550.

Equitable tolling and waiver or estoppel in cases of misconduct or unreasonableness are precisely the types of background rules that, "in the absence of a contrary agreement," *McCutchen*, 133 S. Ct. at 1550, parties will expect courts to apply. *See, e.g.*, *Irwin*, 498 U.S. at 95 ("Time requirements in lawsuits between private litigants are customarily subject to 'equitable tolling.'"); *Cange*, 826 F.2d at 585 (doctrine of estoppel is "'deeply rooted in and integral to our jurisprudence'"). The Policy says nothing to oust these doctrines. When a plan "leaves space" for background equitable rules to apply, it does not offend the parties' reasonable expectations or the written-plan requirement to apply them. *McCutchen*, 133 S. Ct. at 1549. It is Ms. Heimeshoff's call for wholesale revision or invalidation of the limitations provision that would do maximal violence to the written plan.

3. "Automatic" tolling is unavailable

For the first time in this Court, Ms. Heimeshoff argues (at 33-39) that if the Policy's limitations provision applies, state law tolls the period automatically pending exhaustion of administrative remedies. This argument is waived. Below, Ms. Heimeshoff sought case-specific "equitable tolling" based on Hartford's alleged failure to provide adequate notice of the limitations period.

Pet. C.A. Br. 50. That is the argument the lower courts considered and rejected, Pet. App. 4, 15-18, and as to which this Court denied review, *see* Pet. i, 2-3, 11, 31-37. Ms. Heimeshoff's new argument is fundamentally different: She calls for automatic tolling in all cases, without regard to the claimant's diligence or other case-specific circumstances. Pet. Br. 33-39. She did not present this argument below, nor did the parties brief the many subsidiary questions it raises. The Court should not consider it. *E.g.*, *Sprietsma* v. *Mercury Marine*, 537 U.S. 51, 56 n.4 (2002).

In any event, *McCutchen* forecloses the argument. Even if automatic tolling of the type Ms. Heimeshoff seeks were a settled feature of applicable law—and it is not—applying it to override plan terms would violate ERISA. The Policy specifies the length of the limitations period and the time the period begins to run. An automatic tolling rule would effectively nullify those terms. Where "[t]he express contract term ... contradicts" the purported background rule, "the agreement must govern." *McCutchen*, 133 S. Ct. at 1549; *see also Amara*, 131 S. Ct. at 1877 (court cannot alter plan terms "where that change, akin to reforming a contract, seems less like the simple enforcement of a contract as written and more like an equitable remedy").

Ms. Heimeshoff is also wrong about the purported background rule. This Court's tolling principles require the party seeking relief to demonstrate that he exercised reasonable diligence and that "'some extraordinary circumstance stood in his way.'" *Holland* v. *Florida*, 130 S. Ct. 2549, 2562 (2010); *see also Rotella* v. *Wood*, 528 U.S. 549, 560-561 (2000) (tolling is "the exception, not the rule"); *Irwin*, 498 U.S. at 96 (tolling applies "sparingly" and not when a "claimant failed to exercise due diligence"). Thus, in *Wallace*, 549 U.S. at

396, the Court rejected an "omnibus tolling" approach under which the statute of limitations on a false imprisonment claim would be tolled automatically while suit was barred by *Heck* v. *Humphrey*. The Court explained: "[e]quitable tolling is a rare remedy to be applied in unusual circumstances, not a cure-all for an entirely common state of affairs." *Id.* Similarly, in *Pace* v. *DiGuglielmo*, 544 U.S. 408, 418 (2005), the Court held that even where an exhaustion requirement prevented the petitioner from filing suit, the petitioner was "not ... entitled to relief because he ha[d] not established the requisite diligence." *See also Baldwin Cnty. Welcome Ctr.* v. *Brown*, 466 U.S. 147, 151 (1984) ("One who fails to act diligently cannot invoke equitable principles to excuse that lack of diligence.").[22]

Other federal courts have followed suit, holding that tolling applies during the pendency of administrative proceedings "'only when [a] plaintiff is *prevented from filing* despite exercising that level of diligence which could reasonably be expected in the circumstances.'" *Gonzalez* v. *Hasty*, 651 F.3d 318, 322 (2d Cir. 2011); *see, e.g.*, *Smith* v. *McGinnis*, 208 F.3d 13, 17-18 (2d Cir. 2000); *Heck* v. *Humphrey*, 997 F.2d 355, 357 (7th Cir. 1993), *aff'd*, 512 U.S. 477 (1994).[23] A tolling principle that takes no account of diligence is thus far from the "strong and uniform" background rule that

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[22] Ms. Heimeshoff cites (at 35-36) *Johnson* v. *Railway Express Agency, Inc.*, 421 U.S. 454, 463 (1975), but that decision *rejected* the application of tolling.

[23] Every decision Ms. Heimeshoff cites (at 37 n.9) tolling the limitations period under the Prison Litigation Reform Act either applied state law (or cited precedent applying state law), refused to apply automatic tolling, or applied tolling only where the plaintiff acted diligently.

the drafters of an ERISA plan would expect to apply. *McCutchen*, 133 S. Ct. at 1549.

Nor would state law support Ms. Heimeshoff's position, even if it applied.[24] Connecticut law holds that "'[c]ontracting parties are free to adopt an unambiguous contract provision' limiting the time in which an insurance claim must be filed," and "when they do so, 'failure to comply with the terms therein bar[s] recovery.'" *Voris* v. *Middlesex Mut. Assurance Co.*, 999 A.2d 741, 748 (Conn. 2010); *see also Chambers*, 1883 WL 1583, at *1-2 (applying insurance policy limitations provision without tolling during 60-day waiting period); *Chichester*, 51 A. at 547 (determining whether waiver or estoppel apply by reference to facts of particular case).[25]

Practice in other States is both irrelevant and varied. *Supra* n.24. In the insurance context, although a minority of state courts toll the limitations period during a 60-day waiting period, "[t]he majority of courts have refused to toll a limitations provision during the initial non-suit period or during the insurer's investiga-

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[24] State law does not govern the availability of tolling here. When federal courts borrow a state statute of limitations, they also borrow the tolling principles of the same State. *Hardin* v. *Straub*, 490 U.S. 536, 539 (1989); *Board of Regents of Univ. of State of N.Y.* v. *Tomanio*, 446 U.S. 478, 483-484 (1980). But if the Policy's limitations provision is enforceable (a question of federal law), no borrowing occurs.

[25] In *Perzanowski* v. *City of New Britain*, 440 A.2d 763, 765 (Conn. 1981), the court *declined* to toll a statute of limitations pending an earlier action and recognized only that tolling *might* apply in cases where "the pendency of the prior action ... prevent[s] enforcement of the remedy sought in the later action." *See also Gager* v. *Sanger*, 897 A.2d 704, 709 (Conn. App. Ct. 2006).

tion." *FDIC* v. *Hartford Accident & Indem.*, 97 F.3d at 1150 (collecting cases). Many of the cases Ms. Heimeshoff cites apply tolling only as a case-specific principle requiring a showing of diligence. *E.g.*, *Braxton* v. *Zavaras*, 614 F.3d 1156, 1160 (10th Cir. 2010). Of the minority of States Ms. Heimeshoff cites that recognize a version of automatic tolling, most do so only by statute. State practice thus provides scant support for Ms. Heimeshoff's assertion of a general, common-law principle of automatic tolling that applies even where a plaintiff has slept on her rights.

* * *

Applying automatic tolling as Ms. Heimeshoff suggests—without regard to a claimant's diligence, and motivated only by bare conjecture that ERISA's remedial scheme *might* be frustrated in a theoretical case—would effectively nullify the Policy's express limitations provision, no differently than if the Court held the provision categorically unenforceable. Either course would contravene a century of precedent upholding the right of contracting parties to adopt a reasonable limitations provision and would impermissibly rewrite the terms of the plan. Whether a categorical rule prohibiting enforcement of a proof-of-loss limitations provision would improve or disrupt the resolution of ERISA claims is a policy judgment that should be informed by empirical investigation and consider the competing interests of claimants and plans, including insurers' obligation under state law to include the provision in their policies. Crafting such a rule in this case would exceed "the scope of permissible judicial innovation." *Black & Decker*, 538 U.S. at 831.

CONCLUSION

The court of appeals' judgment should be affirmed.

Respectfully submitted.

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APPENDIX

29 U.S.C. §1102. Establishment of plan

(a) Named fiduciaries

(1) Every employee benefit plan shall be established and maintained pursuant to a written instrument. Such instrument shall provide for one or more named fiduciaries who jointly or severally shall have authority to control and manage the operation and administration of the plan.

* * *

29 U.S.C. §1104. Fiduciary duties

(a) Prudent man standard of care

(1) Subject to sections 1103(c) and (d), 1342, and 1344 of this title, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and—

(A) for the exclusive purpose of:

(i) providing benefits to participants and their beneficiaries; and

(ii) defraying reasonable expenses of administering the plan;

(B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;

(C) by diversifying the investments of the plan so as to minimize the risk of large losses, unless un-

der the circumstances it is clearly prudent not to do so; and

(D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter and subchapter III of this chapter

* * *

29 U.S.C. § 1113. Limitation of actions

No action may be commenced under this subchapter with respect to a fiduciary's breach of any responsibility, duty, or obligation under this part, or with respect to a violation of this part, after the earlier of—

(1) six years after (A) the date of the last action which constituted a part of the breach or violation, or (B) in the case of an omission the latest date on which the fiduciary could have cured the breach or violation, or

(2) three years after the earliest date on which the plaintiff had actual knowledge of the breach or violation;

except that in the case of fraud or concealment, such action may be commenced not later than six years after the date of discovery of such breach or violation.

29 U.S.C. § 1132. Civil enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought—

(1) by a participant or beneficiary—

* * *

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

* * *

29 U.S.C. § 1133. Claims procedure

In accordance with regulations of the Secretary, every employee benefit plan shall—

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

29 C.F.R. § 2560.503-1. Claims procedure.

* * *

(c) *Group health plans.* The claims procedures of a group health plan will be deemed to be reasonable only if, in addition to complying with the requirements of paragraph (b) of this section—

* * *

(3) To the extent that a plan offers voluntary levels of appeal (except to the extent that the plan is required to do so by State law), including voluntary arbitration or any other form of dispute resolution, in addition to those permitted by paragraph (c)(2) of this section, the claims procedures provide that:

(i) The plan waives any right to assert that a claimant has failed to exhaust administrative remedies because the claimant did not elect to submit a benefit dispute to any such voluntary level of appeal provided by the plan;

(ii) The plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that any such voluntary appeal is pending;

* * *

(d) *Plans providing disability benefits.* The claims procedures of a plan that provides disability benefits will be deemed to be reasonable only if the claims procedures comply, with respect to claims for disability benefits, with the requirements of paragraphs (b), (c)(2), (c)(3), and (c)(4) of this section.

* * *

(f) *Timing of notification of benefit determination—*

* * *

(3) *Disability claims.* In the case of a claim for disability benefits, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the plan. This period may be extended by the plan for up to 30 days, provided that the plan administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If, prior to the end of the first 30-day extension period, the administrator determines that, due to matters beyond the control of the plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the plan administrator notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the plan expects to render a decision. In the case of any extension under this paragraph (f)(3), the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the

claimant shall be afforded at least 45 days within which to provide the specified information.

(4) *Calculating time periods.* For purposes of paragraph (f) of this section, the period of time within which a benefit determination is required to be made shall begin at the time a claim is filed in accordance with the reasonable procedures of a plan, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph (f)(2)(iii) or (f)(3) of this section due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

* * *

(h) *Appeal of adverse benefit determinations*—(1) *In general.* Every employee benefit plan shall establish and maintain a procedure by which a claimant shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the plan, and under which there will be a full and fair review of the claim and the adverse benefit determination.

* * *

(3) *Group health plans.* The claims procedures of a group health plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless, in addition to complying with

the requirements of paragraphs (h)(2)(ii) through (iv) of this section, the claims procedures—

(i) Provide claimants at least 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

* * *

(4) *Plans providing disability benefits.* The claims procedures of a plan providing disability benefits will not, with respect to claims for such benefits, be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures comply with the requirements of paragraphs (h)(2)(ii) through (iv) and (h)(3)(i) through (v) of this section.

(i) *Timing of notification of benefit determination on review*—(1) *In general.* (i) Except as provided in paragraphs (i)(1)(ii), (i)(2), and (i)(3) of this section, the plan administrator shall notify a claimant in accordance with paragraph (j) of this section of the plan's benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the claimant's request for review by the plan, unless the plan administrator determines that special circumstances (such as the need to hold a hearing, if the plan's procedures provide for a hearing) require an extension of time for processing the claim. If the plan administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice shall indicate the special

circumstances requiring an extension of time and the date by which the plan expects to render the determination on review.

* * *

(3) *Disability claims.* (i) Except as provided in paragraph (i)(3)(ii) of this section, claims involving disability benefits (whether the plan provides for one or two appeals) shall be governed by paragraph (i)(1) of this section, except that a period of 45 days shall apply instead of 60 days for purposes of that paragraph.

* * *

(4) *Calculating time periods.* For purposes of paragraph (i) of this section, the period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the reasonable procedures of a plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph (i)(1), (i)(2)(iii)(B), or (i)(3) of this section due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

* * *

(*l*) Failure to establish and follow reasonable claims procedures. In the case of the failure of a plan to establish or follow claims procedures consistent with the re-

quirements of this section, a claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies under section 502(a) of the Act on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

* * *

THE
HARTFORD

August 4, 2006

Steven Krafchick
2701 First Ave.
#340
Seattle, WA 98121
Attn: Julia Busko

Policy Holder: Wal-Mart Stores, Inc.
Associate: Julie E. Heimeshoff
Policy Number: GLT024554

Dear Ms. Busko:

This letter is about your client's claim for Long Term Disability (LTD) benefits. I am in receipt of your 08/02/06 letter. To answer your question, if indeed you plan get the information from Dr. Saitta regarding Ms. Heimeshoff's functionality, then you do not need to appeal and you can disregard 06/12/06 letter. If, however, you do not plan to get the information we had requested from Dr. Saitta on Julie's functionality, then you do need to proceed with the appeal.

If you have any questions, please feel free to contact our office at (800) 492-5678, x64230. Our office hours are 8:00 AM to 8:00 PM EST, Monday through Friday.

Sincerely,

John Wentworth, Senior Examiner
Hartford Life and Accident Insurance Co.

Benefit Management Services
Atlanta Disability Claim Office
P.O. Box 1810

Alpharetta, GA 30023-1810
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August 14, 2006

Via Facsimile Only: 860-392-0713

John Wentworth
Hartford Life Insurance Company
Benefits Management Services
PO Box 2999
Hartford, CT 06104

Re:	Our Client:	Julie Heimeshoff
	Your Insured:	Julie E. Heimeshoff
	Claim No.:	GLT024554
	Date of Loss:	12/8/2005

Dear Mr. Wentworth:

Thank you for your letter dated August 4, 2006. We are working on providing to you the "written proof of loss" you are requesting in order to reopen Ms. Heimeshoff's claim for long term disability benefits. We do intend to obtain information from Dr. Saitta, so, as we understand, we are not appealing, but we are working within the original claim determination.

Due to summer vacations and doctor schedules, we will not have that information for you by August 18, 2006. To permit full and fair review we require additional time to support Ms. Heimeshoff s claim. We ask that you give us at least an addition 45 days, to October 2, 2006 to submit material for your consideration. We

agree that the time for you to complete review will toll until we submit our additional material.

If we do not hear from you on or by August 17, 2006, we will assume you agree to give us the extra time. Thank you.

Very truly yours,

KRAFCHICK LAW FIRM

/s/ Steven P. Krafchick

Steven P. Krafchick

cc: Client

2701 First Avenue, Suite 340 Seattle, Washington
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REPLY BRIEF

Supreme Court, U.S.
FILED
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No. 12-729

IN THE
Supreme Court of the United States

JULIE HEIMESHOFF,

Petitioner,

v.

HARTFORD LIFE & ACCIDENT INSURANCE CO. AND WAL-MART STORES, INC.,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

REPLY BRIEF FOR PETITIONER

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September 2013

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INTRODUCTION

Respondents ask the Court to "imagine" a one-year statute of limitations for ERISA denial-of-benefit claims running from the date of final denial. Resp. Br. 1. They assert that such a statute of limitations would be valid and ask whether their three-year statute of limitations provision—which starts the clock running not from final denial but from a point much earlier, when "proof of loss" is due—should be viewed any differently. The answer, in a word, is yes.

A one-year statute of limitations that starts running when a claim can be filed in court complies with basic, longstanding federal limitations principles; is clear and concrete from the outset; encourages participation in and deters manipulation of ERISA's internal benefits resolution process; and avoids enmeshing the federal courts in an endless series of post hoc "case-specific" adjudications over whether the application of a "proof-of-loss" accrual date is "reasonable[]" or barred by "traditional equitable principles," including "estoppel and waiver, [and] equitable tolling." *Id.* at 14, 48-49. Respondents' limitations provision does none of these things. As the United States put it, Respondents' provision "is inconsistent with ERISA's two-tiered remedial scheme," and their "ad hoc approach" to enforcing it fails to "furnish the clear, predictable rules necessary to avoid distorting the parties' incentives." U.S. Br. 7.

In her opening brief, Petitioner asked why any player in ERISA—participants, plan fiduciaries, or courts—would want such a provision. Respondents

answered this question with a shrug, offering no reason other than that "proof-of-loss" accrual provisions are "ubiquitous" in state insurance contexts. Resp. Br. 16. That answer is telling: State insurance contexts look nothing like ERISA precisely because they do not require claimants to exhaust a mandatory internal resolution process before filing suit in court. Respondents cannot escape the fact that, in every other context involving mandatory exhaustion, the statute of limitations does not begin to run until a claim is ripe for judicial review. ERISA is no different.

To be sure, ERISA plans are free to implement a limitations provision that "assures fairness to defendants by preventing fraudulent and stale claims," *id.* at 5, but that right may not come at the expense of ERISA's comprehensive remedial scheme or the standard federal rule—incorporated into ERISA for denial-of-benefit claims—that a limitations period may not begin running until the claim can be filed in court. Nor does it need to. The judgment should be reversed.

ARGUMENT

I. Respondents' Accrual Provision Violates the Longstanding Rule that, Unless Congress Says Otherwise, a Statute of Limitations Cannot Start Running Before a Claim Can Be Filed in Court.

A. Respondents have no real answer to the fact that, under longstanding precedent of this Court, the limitations period for a federal statutory cause of action cannot "commence to run on one day while the right to sue ripen[s] on a later day . . . unless *the*

statute indicates otherwise." *TRW Inc. v. Andrews*, 534 U.S. 19, 34 n.6 (2001) (emphasis added). *See also Wallace v. Kato*, 549 U.S. 384, 388 (2007); *Bay Area Laundry & Dry Cleaning Pension Trust Fund v. Ferbar Corp.*, 522 U.S. 192, 200-01 (1997). Because ERISA lacks any accrual provision with regard to denial-of-benefit claims under § 502(a)(1)(B). the statute does not "indicate[] otherwise." *TRW Inc.*, 534 U.S. at 34 n.6. As the United States explains, Congress's silence indicates that it expected this well-established accrual rule to apply. U.S. Br. 6.

Respondents acknowledge that this rule exists, but argue that it is merely a "default rule of statutory interpretation" that does not prohibit a contracting party from specifying an accrual date for a federal cause of action that precedes the date the claim could be filed in court. Resp. Br. 28. Respondents' best cases. however, prove the opposite. Both *Dodd v. United States*. 545 U.S. 353 (2005). and *McMahon v. United States*, 342 U.S. 25 (1951), involved federal statutes in which *Congress*—not a contracting party—chose to depart from the standard rule by explicitly establishing an accrual date that precedes the date that a federal claim may be filed in court. *See Dodd*, 545 U.S. at 358-60 (noting that the "plain text" of the statute "clearly specifies" that the limitations period on a federal habeas claim "begins to run" before some plaintiffs could file their claims in court); *McMahon*, 342 U.S. at 27 (holding that. based on the "language used in the Suits in Admiralty Act," the "period of limitation is to be computed from the date of the injury").

Respondents see these cases as proof that their limitations provision is appropriate. *See* Resp. Br. 33 (arguing that their limitations provision is "like the one in *Dodd*" because it sets the clock running "at a time other than the cause of action's 'accrual'"). But that gets it exactly backward. As we and the United States explained (Pet'r Br. 27-28; U.S. Br. 13-14), these cases confirm that only *Congress* can override the general accrual rule, by saying so explicitly in the statute itself. Had Congress said that a limitations period for § 502(a)(1)(B) denial-of-benefits claims could commence at a point before a plaintiff could file that claim in court (as it has for § 502(a)(2) claims, *see* Pet'r Br. 28), Respondents' accrual provision would not offend the statute. "[A]bsen[t] . . . any such indication," however, the limitations period does not begin to run until a plaintiff can file her claim in court. *Reiter v. Cooper*, 507 U.S. 258, 267 (1993).[1]

Respondents fare no better in claiming that this rule applies only to statutes that actually use the word "accrues," Resp. Br. 28, or where a "statutory limitations provision" is "ambiguous," *id.* at 30. There are myriad other statutory schemes lacking either feature in which the limitations period on a federal claim does not begin to run until the claim is ripe for judicial review. *See, e.g., Wallace*, 549 U.S. at

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[1] Even Respondents' state cases make this point. *See, e.g., Proc v. Home Ins. Co.*, 217 N.E.2d 136, 139 (N.Y. 1966) ("In view of the pains taken by *the Legislature* to delineate the precise starting point of the period of limitations . . . [t]he court will not subvert this clearly expressed legislative design[.]") (emphasis added).

388 (42 U.S.C. § 1983); *Randall v. Laconia, NH*, 679 F.3d 1, 6-7 (1st Cir. 2012) (42 U.S.C. § 4852d); *Frame v. City of Arlington*, 657 F.3d 215, 238 (5th Cir. 2011) (42 U.S.C. § 12132); *Wike v. Vertue, Inc.*, 566 F.3d 590, 593 (6th Cir. 2009) (15 U.S.C. §§ 1693 *et seq.*); *Stanley v. Trustees of Cal. State Univ.*, 433 F.3d 1129, 1136 (9th Cir. 2006) (20 U.S.C. § 1681); *California v. Neville Chem. Co.*, 358 F.3d 661, 667-68 (9th Cir. 2004) (42 U.S.C. §§ 9601 *et seq.*); *Snow v. First Am. Title Ins. Co.*, 332 F.3d 356, 359-60 (5th Cir. 2003) (12 U.S.C. §§ 2601 *et seq.*); *Wachtel v. West*, 476 F.2d 1062, 1065-66 (6th Cir. 1973) (15 U.S.C. §§ 1601 *et seq.*). These cases confirm that it is a matter of "basic limitations principles"—not the existence of magic words like "accrue"—that a limitations period cannot commence before the right to sue ripens unless the statute indicates otherwise. *Bay Area Laundry*, 522 U.S. at 201.

B. Respondents are therefore left with one lone assertion: That, because some courts have permitted parties to shorten the *length* of a limitations period, it "follows" that parties can also "choose the starting point from which the limitations period is measured." Resp Br. 19. This argument wrongly assumes that the rules governing the *length* of a limitations period are the same as those governing the date on which a federal statutory cause of action *accrues* for limitations purposes. They are not.

Where Congress has not specified a limitations period for a federal cause of action, the length of that period is ordinarily borrowed from state law. *See, e.g., Johnson v. Ry. Express Agency, Inc.*, 421 U.S. 454, 464 (1975). And, where permissible, the length

of the period can also be stipulated to by the parties. *See, e.g., Mo., K. & T.R. Co. v. Harriman Bros.*, 227 U.S. 657, 672-73 (1913). But "the accrual date of a [federal statutory] cause of action" is a "question of federal law" that is *not* resolved by the same rules governing the length of a limitations period. *Wallace*, 549 U.S. at 388; *Cope v. Anderson*, 331 U.S. 461, 464 (1947); *see also* U.S. Br. 14. Instead, unless Congress has specified otherwise, the limitations clock for a federal statutory claim begins to run when the claim is ripe for judicial review.

That is why Respondents' cases permitting parties to shorten the length of a limitations period do not further their cause. *See* Resp. Br. 16-19 (citing, among others, *Order of United Commercial Travelers of America v. Wolfe*, 331 U.S. 586, 608 (1947), and *Riddlesbarger v. Hartford Insurance Co.*, 74 U.S. (7 Wall.) 386, 390 (1869)). These cases merely stand for the uncontroversial proposition that, where a federal statute is silent as to the length of a limitations period and state law does not indicate otherwise, parties may stipulate to a "shorter period" for bringing an action. *Wolfe*, 331 U.S. at 608 (authorizing shorter period "absent a controlling statute to the contrary"); *Riddlesbarger*, 74 U.S. (7 Wall.) at 390 (same). That makes sense for statutory claims where Congress has not itself specified a limitations period (as in *Wolfe* and *Riddlesbarger*), because the "*length* of [a limitations] period" is "necessarily arbitrary" and "reflects a value judgment concerning the point at which the interests in favor of protecting valid claims are outweighed by the interests in prohibiting the prosecution of stale ones." *Johnson*, 421 U.S. at 463-64 (emphasis added).

In the absence of Congress's "value judgment," parties remain free to make this choice themselves.

What is not "arbitrary," and therefore not open to alteration, is the point at which the limitations period commences. For federal statutes, Congress controls this feature of law, either by incorporating the "standard rule" that a limitations period commences when a claim is ripe for judicial review or by departing from it with specific language. *See TRW Inc.*, 534 U.S. at 34 n.6. Permitting parties, or courts, to override this basic federal principle—against which Congress has legislated for well over a century—would "rip" the rule "from its berth," *id.*, "reverse prior congressional judgments," and "make[] all unspecifying new legislation a roll of the dice," *id.* at 38 (Scalia, J., concurring in judgment). Congress cannot have intended that result when it enacted ERISA.

II. Respondents' Accrual Provision Undermines ERISA's Remedial Framework and Written-Plan Requirement and Generates a Host of Real-World Problems.

Respondents' accrual provision is also "at odds with the purpose [and] operation" of ERISA—in particular the statute's remedial scheme and written-plan requirement—and creates a panoply of real-world problems. *DelCostello v. Int'l Bhd. of Teamsters*, 462 U.S. 151, 161 (1983). The provision is therefore invalid. *See U.S. Airways, Inc. v. McCutchen*, ___ U.S. ___, 133 S. Ct. 1537, 1548 (2013) (plan terms only enforceable insofar as they "accord with the statute") (citing 29 U.S.C. § 1104(a)(1)(D)); *Midstate Horticultural Co. v. Penn.*

R.R. Co., 320 U.S. 356, 358 (1943) ("[A]n agreement is invalid" where it is "contrary to the intent and effect" of a federal statute.); *see also Hardin v. Straub*, 490 U.S. 536, 538-39 (1989) (borrowing features of a state statute of limitations not appropriate where they would "defeat the goals of the federal statute at issue").

A. As previously explained, a limitations provision that starts the clock ticking on a federal statutory claim before the completion of a mandatory administrative proceeding is incompatible with the statute's remedial framework because it both undermines the non-judicial process and jeopardizes the right to file a statutorily guaranteed claim. *See* Pet'r Br. 22-25, 39-43; *see also Crown Coat Front Co. v. United States*, 386 U.S. 503, 514 (1967). The United States agrees. *See* U.S. Br. 19.

And so held this Court in *Occidental Life Insurance Co. of California v. EEOC*, 432 U.S. 355 (1977), which invalidated an accrual provision uncannily similar to Respondents'. There, a California state statute of limitations provided one year to file a Title VII discrimination claim and tied the start of the period not to the accrual of the cause of action but instead to the administrative filing of the claim. *Id.* at 357-58. *Occidental* refused to enforce the provision on the ground that, because a Title VII claim is conditioned on the completion of a mandatory administrative process, starting the limitations period running at the start of the administrative process "would be inconsistent with the underlying policies of the federal statute." 432 U.S. at 367.

Occidental is particularly relevant here because of the striking parallels between Title VII and ERISA. Like ERISA, Title VII contains no explicit statute of limitations and establishes an "overall enforcement structure" that includes "a sequential series of steps beginning with" an "informal, noncoercive" pre-suit administrative procedure that, by law, must be exhausted before "commencing a civil action." *Id.* at 368, 392. The *Occidental* Court held that the state's limitations period, which started the clock ticking before completion of the administrative process, was incompatible with Title VII's two-tiered remedial framework: "In view of the federal policy requiring employment discrimination claims to be . . . administratively resolved before suit is brought in a federal court," it would be "hardly appropriate" to permit a limitations provision that did not "take[] into account the decision of Congress to delay judicial action while the EEOC performs its administrative responsibilities." *Id.* at 368.

Occidental's reasoning has been adopted across the board for federal regimes that require exhaustion of an internal process before commencing suit. *See* Pet'r Br. 22-25; *see also Frandsen v. Bhd. of Ry., Airline & S.S. Clerks, Freight Handlers, Express & Station Emps.*, 782 F.2d 674, 681 (7th Cir. 1986) (starting limitations clock before plaintiff has exhausted mandatory internal remedies "would contravene the . . . policy of encouraging workers to pursue internal . . . remedies, while ensuring them a judicial forum in which to resolve disputes").

Respondents counter that "[a]ll these schemes show is that there is more than one way to draft a limitations period." Resp. Br. 30 n.11. But they in fact show the opposite. For claims conditioned on the

exhaustion of a mandatory administrative or internal process, there is *only one* way to draft a limitations period compatible with the statute's structure and objectives: Start it running when the administrative process is complete, and not before.

Not surprisingly, Respondents identify *no* case where this Court, or any other, has embraced their novel position that uncoupling the commencement of a limitations period from the accrual of a federal statutory cause of action is consistent with the remedial policies of a statute that conditions a federal claim on the exhaustion of a mandatory pre-suit process. This lack of authority makes sense, because it defies "logic" to assert, as Respondents do, that the clock on this type of claim could start running, and possibly even run out, before the administrative process is complete. *Ortiz v. Sec'y of Def.*, 41 F.3d 738, 743 (D.C. Cir. 1994); *see United States v. Meyer*, 808 F.2d 912, 916 (1st Cir. 1987) (observing that, with one exception not relevant here, "no court has ever held that, in a case where an antecedent administrative judgment is a statutory prerequisite to the maintenance of a civil enforcement action, the limitations period on a recovery suit runs from the date of the underlying violation as opposed to the date on which the penalty was administratively imposed"). As the United States explained. such a result is incompatible with ERISA, "because it sets the two procedures for redress—internal claim processes and judicial review—against each other, thereby undermining the availability and efficacy of both." U.S. Br. 19.

The upshot: Where a federal statutory claim is conditioned on the exhaustion of a mandatory pre-suit process, a limitations provision that starts the

clock running before completion of that process is incompatible with the policies and objectives of the statute. Because Respondents' limitations provision does not take into account the "delay[ed] judicial action" premised on the completion of the internal resolutions benefits process, it "frustrates" the federal policies of the statute and cannot stand. *Occidental*, 432 U.S. at 367, 368.

It is no answer to say (as Respondents and their *amici* repeatedly do) that accrual provisions starting the limitations clock running when "proof of loss" is due, rather than when the claim is ripe, are used "ubiquitous[ly]" outside of ERISA, particularly in certain state insurance contexts. Resp. Br. 5-6, 16, 20-21. As explained in our opening brief and echoed by the United States, state insurance "proof-of-loss" provisions say nothing about the validity of such a provision in ERISA, because state insurance claimants are not required to exhaust a lengthy and indeterminate internal resolution process before proceeding to court. Pet'r Br. 31-32; U.S. Br. 29-30. Inserting a "proof-of-loss" accrual date into a statutory scheme that requires exhaustion of internal remedies would leave ERISA beneficiaries with less protection for their benefits than they would have under state law alone—an outcome that contradicts ERISA's "desire to offer employees *enhanced* protection for their benefits." *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996) (emphasis added).

Moreover, Respondents' repeated suggestion that, under state law, they are required to include their "proof-of-loss" language is false. Resp. Br. 5-6, 20-21, 36. First, they have already conceded that Connecticut state law does not require any particular accrual provisions in group disability insurance

policies. *See* Brief in Opposition (BIO) 22 n.11. Second, the "vast majority" of states do not require *any* insurer to use the language Respondents have used. Resp. Br. 6. Respondents' plan starts the clock ticking "90 days *after the start of the period* for which The Hartford owes payment." BIO App. 5a, 7a (emphasis added). But most states with a "proof-of-loss" requirement—including Connecticut—require that the limitations clock run from "ninety (90) days *after the termination of the period* for which the insurer is liable." *Wetzel v. Lou Ehlers Cadillac Grp. Long Term Disability Ins. Program*, 222 F.3d 643, 647 n.5 (9th Cir. 2000) (emphasis added); *see also* Conn. Gen. Stat. § 38a-483(a)(7). But even if state law required Respondents to use the "proof-of-loss" language at issue here, that requirement would be likely preempted under ERISA. U.S. Br. 28 n.5.

At the same time, Respondents completely ignore the one state insurance context—Underinsured Motorist (UIM) insurance—that *does* condition a legal claim on the completion of an internal resolution process. Some UIM insurers have sought to do precisely what Respondents seek to do here—run the limitations clock from a point in time before the claim is ripe for judicial review—and state courts have repeatedly rejected these attempts as unfair and illogical. *See McDonnell v. State Farm Mut. Auto. Ins. Co.*, 299 P.3d 715, 733 (Alaska 2013) (rejecting as "illogical and unreasonable" an insurer's contractual limitations provision that started the clock ticking before accrual because such a provision would "considerably reduce the insured's time to file suit"); *State Farm Mut. Auto. Ins. Co. v. Fitts*, 99 P.3d 1160, 1162-63 (Nev. 2004) (same, noting that it would burden the courts as well as insureds by

forcing protective filing of claims simply in order to preserve them); *Nicodemus v. Milwaukee Mut. Ins. Co.*, 612 N.W.2d 785, 788-89 (Iowa 2000) (same).

B. Respondents' accrual provision also runs afoul of ERISA's written-plan requirement and would enmesh the federal courts in endless litigation over "reasonableness."

Here is how Respondents characterize their approach:

- Requiring a "case-by-case inquiry into . . . reasonableness," BIO 24, and "case-specific adjustment" of limitations provisions, Resp. Br. 14.
- Mandating that courts "develop[] tests to assess the reasonableness of [a] limitations period[]." *Id.* at 47.
- Depending on courts to police limitations provisions for "waiver," "estoppel," and "equitable tolling." *Id.* at 14.
- Necessitating that courts determine, in every case, when "proof of loss" was due. *Id.* at 42 n.19, 44 n.20.

These very words make clear that Respondents' approach violates ERISA's written-plan requirement. That requirement is designed to ensure that "every employee may, *on examining the plan documents*, determine exactly what his rights and obligations are under the plan" "*at any time*." *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 83 (1995) (internal citation omitted) (second emphasis added). A contractual limitations period that is, in every case, "subject to reasonableness and traditional equitable

principles," which depend on a host of unpredictable factors, comes nowhere close to satisfying this obligation. Resp. Br. 48-49.

Respondents attempt to downplay the unwieldiness of their approach by arguing that these "background rules" are no different from those endorsed by this Court in *U.S. Airways*. *See id.* at 49 ("When a plan 'leaves space' for background equitable rules to apply, it does not offend the parties' reasonable expectations or the written-plan requirement to apply them."). But consider the very different background rule at issue in *U.S. Airways*—whether the "common fund doctrine" applied in the absence of a clear disclaimer in the plan language to require a plan fiduciary to offset its lien by an appropriate amount of attorney's fees. 133 S. Ct. at 1548. Consulting a plan's reimbursement provision, both employees and plan fiduciaries could easily ascertain whether this background rule would apply and, more importantly, *how* it would apply, down the road if or when the provision triggered.

Respondents' "background rules" provide no similar certainty. Yes, a party might know that these principles *may* apply, but he or she will never know *if* or *how* they will apply. Under Respondents' approach, no party to an ERISA plan has any way to know with certainty what rights and obligations exist under the plan. Will a court invalidate the accrual provision? Blue-pencil it by adding several additional months onto the limitations period? Toll the time for filing a claim? Enforce it? No one—not even Respondents—can have any idea until it happens in a particular case under particular facts. This result, as the United States pointed out, "is directly contrary to ERISA's goal of fostering a

predictable set of liabilities" and "a uniform regime of ultimate remedial orders." U.S. Br. 27 (internal quotations omitted).[2]

Indeed, many courts have already struggled with some of these criteria. For example, the question of whether running the clock from when "proof of loss" is due is "reasonable" has been the subject of extensive litigation, and different courts have reached differing conclusions about the same time periods. *E.g.*, *compare Hinojos v. Prudential Ins. Co. of Am.*, 2011 WL 7768621, at *6-*7 (D.N.M. Oct. 19, 2011) (five-month period to file suit was unreasonable), *with Rotondi v. Hartford Life & Accident Grp.*, 2010 WL 3720830, at *8 (S.D.N.Y. Sept. 22, 2010) (five months was reasonable); *compare McVicker v. Blue Shield of Cal.*, 2007 WL 3407433, at *6 (N.D. Cal. Nov. 13, 2007) (two-year

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[2] Ultimately, Respondents' *U.S. Airways*-based argument leads them into an indefensible position. Respondents argue that their altered accrual provision is valid because it is *necessarily* "subject to reasonableness and traditional equitable principles," so as to protect against the possibility that the time will run before a plaintiff can file in court. Resp. Br. 48-49. But they abruptly shift gears and assert that these protective doctrines can be "oust[ed]" simply via plan language disclaiming them. *See id.* at 49 (stating that these doctrines are "background rules" that apply only "in the absence of a contrary agreement"). So, under Respondents' theory, it would be permissible and enforceable to include a three-year limitations period that (1) runs from the date "proof of loss" is due and (2) disclaims the precise doctrines (equitable tolling, waiver, estoppel, and reasonableness) that supposedly make this type of limitations provision acceptable in the first place.

period from time of first denial was unreasonable) *with Marquette Gen. Hosp., Inc. v. Starmark Ins. Co.*, 2011 WL 2118582, at *5 (W.D. Mich. May 26, 2011) (two-year period was reasonable).

Litigation is also bound to arise regarding the question of when "proof of loss" is due under a given plan. Respondents claim that since their "proof-of-loss" date is clear, all parties will be able to calculate, with certainty, when the limitations period begins to run. *See* Resp. Br. 39, 47. In reality, however, although the initial proof-of-loss due date in the plan may be clear, confusion arises when the plan requests additional information supporting the participant's claim and imposes a new due date. Indeed, in *this* routine case, as Respondents admit, it remains uncertain whether the Plan's additional request for proof supporting Ms. Heimeshoff's disability, a request that included a new due date, reset the limitations period. *Id.* at n.19. And this case is hardly unique—uncertainty over "proof-of-loss" dates has already triggered substantial litigation, and more is sure to come. *See, e.g.*, *Hyder v. Kemper Nat'l Servs., Inc.*, 302 Fed. App'x 731, 733 (9th Cir. 2008); *Fry v. Hartford Ins. Co.*, 2011 WL 1672474, at *1 (W.D.N.Y. May 3, 2011).

These uncertainties are compounded in cases where the plan participant receives benefits that are later terminated. Most courts, including the only federal court of appeals to consider the question, have held that the original "proof-of-loss" date, when the claimant *first* sought benefits, triggers the statute of limitations. *E.g.*, *Abena v. Metro. Life Ins. Co.*, 544 F.3d 880, 884 (7th Cir. 2008); *Touqan v. Metro. Life Ins. Co.*, 2012 WL 3465493, at *3 (E.D. Mich. Aug. 14, 2012); *Smith v. Unum Provident*, 2012

WL 1436458, at *2 n.1 (W.D. Ky. Apr. 24, 2012). Other courts consider a plan's later request for proof of continuing disability to begin the limitations clock. *E.g.*, *Homesley v. Hartford Life & Accident Ins. Co.*, 2011 WL 2619370, at *3 (W.D. Okla. July 1, 2011); *Rotondi*, 2010 WL 3720830, at *8. Still others view the entire notion that the clock for a claimant's denial-of-benefits claim runs while he is receiving benefits as nonsense. *E.g.*, *Forrest v. Paul Revere Life Ins. Co.*, 662 F. Supp. 2d 183, 191-92 (D. Mass. 2009); *Skipper v. Claims Servs. Int'l*, 213 F. Supp. 2d 4, 6-8 (D. Mass. 2002).

Respondents nonetheless assure the Court that the problems and uncertainty created by their accrual provision are hypothetical and will "virtually never" arise. Resp. Br. 40. But plan exhaustion can—and frequently does—take years in spite of the Department of Labor (DOL) regulations governing the ERISA claims process. *See, e.g.*, *Lamantia v. Voluntary Plan Adm'rs, Inc.*, 401 F.3d 1114, 1120 (9th Cir. 2005) (*four year* period running from date of loss elapsed before claimant could file denial-of-benefits claim); *Hansen v. Aetna Health & Life Ins. Co.*, 1999 WL 1074078, at *4 (D. Or. Nov. 4, 1999) (two year period running from date of loss elapsed before claimant could file denial-of-benefits claim, plan argued that limitations provision was nevertheless "reasonable"). It is therefore false—and demonstrably so—that "even a lengthy administrative review process would still leave ample time to sue." Resp. Br. 45.[3]

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[3] Respondents are wrong in contending that, if the DOL regulations are strictly followed, the maximum time period that

Making matters worse, some plans couple the "proof-of-loss" accrual date with a *shorter* length of time to file suit—one or two years instead of three—and this Court's decision will apply to those plans, too. *See, e.g.*, *Baptist Mem'l Hosp.—DeSoto, Inc. v. Crain Auto. Inc.*, 392 F. App'x 288. 294 (5th Cir. 2010) (one year); *Clark v. Nationwide Mut. Ins. Co.*, ___ F. Supp. 2d ___, 2013 WL 1194927, at *9 (S.D. W. Va. Mar. 22, 2013) (one year); *Skipper*, 213 F. Supp. 2d at 5 (two years); *Wesley v. NMU Pension & Welfare Plan*, 2002 WL 10486, at *1 (S.D.N.Y. Jan. 3. 2002) (two years). For many of these plans, even strict adherence to the DOL regulations could leave an ERISA beneficiary with little or no time to file her claim in court.

To the extent Respondents are concerned about the overall time a participant has to sue, there is no reason that Respondents could not amend their plan to have a shorter limitations period that runs from final denial. Indeed, many plans do. *See, e.g.*, *Scharff*

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exhaustion of the internal review process should take is 375 days, just over a year. Resp. Br. 40. A study of recent cases conducted by one of Respondents' own *amici*—the American Council of Life Insurers—reveals that, in the typical case, exhaustion can take 15 to 16 months. Br. for Am. Council of Life Insurers, et al. as Amici Curiae Supporting Resp. 29. And, as the United States explains, by permitting the time to be tolled when additional proof is requested, the timelines in the DOL regulations are by no means ironclad; to the contrary, they are intended to offer the plan and participant flexibility so that the plan has the opportunity to fully and fairly consider the claim. U.S. Br. 20. Indeed, here, internal exhaustion took 718 days, about two years, and Respondents do not argue that the DOL regulations were violated in this case. *See id.*

v. Raytheon Co. Short Term Disability Plan, 581 F.3d 899, 902 (9th Cir. 2009); *Gibbons v. Qwest*, 2012 WL 6022210, at *1 (D. Utah Dec. 4, 2012).

Respondents cannot even claim that their accrual provision advances any of the objectives behind limitations periods generally. One key purpose of limitations periods is to put defendants on notice of adverse claims. *Crown, Cork & Seal Co. v. Parker*, 462 U.S. 345, 352 (1983). But ERISA's internal review process does just that. *See Occidental*, 432 U.S. at 372 (requiring a limitations period to run from the completion of a pre-suit administrative process "will not . . . deprive defendants . . . of fundamental fairness or subject them to surprise and prejudice that can result from the prosecution of stale claims").

Second, limitations periods encourage potential plaintiffs to file suit before evidence is destroyed and memories fade. *Burnett v. N.Y. Cent. R.R. Co.*, 380 U.S. 424, 428 (1965). But again, when there is an internal review process ongoing, that concern is nonexistent. During internal review of a beneficiary's claim, the relevant evidence is preserved and organized and is ready if and when the beneficiary decides to file suit.

* * *

Although statutes of limitations are designed to protect the potential defendant and preserve evidence, they also reflect a balance made between those interests and the time the potential plaintiff needs to file a claim. *United States v. Kubrick*, 444 U.S. 111, 117 (1979). Applying the federal rule that a claim accrues, and the statute of limitations begins to run when, the plaintiff can bring the claim in

court—here, when the internal review process has been exhausted—preserves that balance and honors the purposes behind statutes of limitation. Respondents' approach does neither.

III. Even If Respondents' "Proof-of-Loss" Accrual Date Is Enforceable, the Limitations Period Does Not Run During Mandatory Exhaustion Because It Is Tolled.

Even if the proof-of-loss accrual date in the Plan is enforceable, Respondents' limitations provision still does not bar this case because the limitations period was tolled while Petitioner pursued the Plan's internal review procedures. Respondents present no authority that contradicts the basic federal law rule that limitation periods are tolled while mandatory pre-suit procedures are exhausted.

Respondents protest, first, that Petitioner waived the tolling argument because she did not make exactly the same assertion below. Resp. Br. 49-50. But once a party properly raises a claim, "a party can make any argument in support of that claim; parties are not limited to the precise arguments they made below." *Yee v. City of Escondido, Cal.*, 503 U.S. 519, 534 (1992). Petitioner's contention that limitations periods are tolled during mandatory pre-suit exhaustion is just another way of supporting the same claim she has been making all along: The limitations period did not run while she exhausted the Plan's review process and, therefore, her suit is timely.

On the merits, Respondents cite no authority—none—contradicting the basic federal rule that when there is mandatory exhaustion of pre-suit

procedures, the limitations period is tolled during those procedures. *See* Corman, Limitations of Actions § 8.4.1, at 10, 15-16 (1991); 51 Am. Jur. 2d Limitation of Actions § 186 (2013); *see also Harris v. Alumax Mill Prods., Inc.*, 897 F.2d 400, 404 (9th Cir. 1990); *Trent v. Bolger*, 837 F.2d 657, 659 (4th Cir. 1988).

Instead, Respondents discuss the standard that applies to a different type of tolling—equitable tolling—that, they say, cannot be satisfied here. Resp. Br. 50. This argument conflates two different categories of tolling. In the category applicable here—exhaustion tolling—tolling applies automatically while a plaintiff pursues a mandatory pre-suit procedure. Corman, Limitations of Actions, § 8.4.1, at 10, 15-16 (1991). In the other—equitable tolling—tolling applies at the discretion of a court when several fact-specific criteria are met. *See, e.g., Irwin v. Dep't of Veterans Affairs*, 498 U.S. 89, 95-96 (1990).

The two tolling doctrines are distinct, as evidenced by the fact that none of Respondents' equitable-tolling cases involves properly pursued mandatory pre-suit proceedings. For instance, in Respondents' key case, *Wallace v. Kato*, there was no mandatory pre-suit exhaustion that precluded the plaintiff from filing his claim. 549 U.S. at 394. For that reason alone, *Wallace*'s discussion of the rules that apply to "equitable" tolling has no relevance here.

Pace v. DiGuglielmo, 544 U.S. 408 (2005), is equally off-point. *Pace* concerned a prisoner's untimely, and therefore improper, pursuit of mandatory pre-suit state relief. *Id.* at 418. The

question was whether "equitable tolling" could nevertheless save the prisoner's claim; the Court concluded it could not. *Id.* at 419. That holding has nothing to do with this case, as Respondents have never alleged that Petitioner failed to properly pursue the Plan's internal procedures.

Besides relying on irrelevant "equitable tolling" cases, Respondents attempt to make hay out of the fact that, in some of the tolling cases, the courts declined to toll the limitations period. Resp. Br. 51 & nn.22-23, 52 n.25. However, these cases are no different from *Wallace* or *Pace*—either the administrative procedure was not mandatory or, if it was, the plaintiffs failed to follow that procedure. *See Johnson*, 421 U.S. at 463 (no tolling because no mandatory pre-suit exhaustion); *Brown v. Valoff*, 422 F.3d 926, 943 (9th Cir. 2011) (no tolling where prisoner failed to exhaust his remedies before filing suit). Ultimately, Respondents cannot explain why it would be acceptable to permit the "unconscionable" result that "the time for suit [will] be consumed" while a plaintiff is exhausting mandatory pre-suit procedures. Couch on Insurance 3d §§ 236:6-236:7, at 236-19 (2000).

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted,

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AMICUS CURIAE BRIEF

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JULIE HEIMESHOFF, PETITIONER

v.

HARTFORD LIFE & ACCIDENT INSURANCE CO., ET AL.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONER

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QUESTION PRESENTED

Under Section 1132(a)(1)(B) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1132(a)(1)(B), a participant in an employee benefit plan may bring a civil action to recover benefits due to him under the terms of the plan. Courts of appeals uniformly require a participant to exhaust available plan remedies before bringing such an action. The question presented is:

Whether the statute of limitations for seeking judicial review of a plan's adverse benefits determination begins running only after the participant has appropriately exhausted plan remedies, notwithstanding a plan provision providing that the limitations period commences before the plan has resolved the claim for benefits.

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Lee R. Russ, *Couch on Insurance 3d* (2000) 30, 31
Horace G. Wood, *Limitations of Actions at Law and at Equity* (1916) 13
H. Rep. No. 533, 93d Cong., 1st Sess. (1973) 10, 17, 18

In the Supreme Court of the United States

No. 12-729

JULIE HEIMESHOFF, PETITIONER

v.

HARTFORD LIFE & ACCIDENT INSURANCE CO., ET AL.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONER

INTEREST OF THE UNITED STATES

The question presented in this case is whether a plan governed by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.*, may provide that the limitations period for seeking judicial review of the plan's denial of benefits begins running before the plan has issued its final determination. The Secretary of Labor has primary authority for administering and enforcing Title I of ERISA, including the authority to implement through regulations the Act's claims administration process. Accordingly, the Secretary has a substantial interest in the proper resolution of this case.

STATEMENT

1. ERISA was enacted to "protect * * * the interests of participants in employee benefit plans and their beneficiaries." 29 U.S.C. 1001(b). While employers have

broad discretion under the statute to decide whether to provide employee benefit plans and what benefits to offer, *Curtiss-Wright Corp.* v. *Schoonejongen*, 514 U.S. 73, 78 (1995), ERISA protects plan participants' entitlement to those benefits by establishing a comprehensive remedial framework that sets forth "standards of conduct, responsibility, and obligation for fiduciaries of [those] plans" and provides "appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C. 1001(b).

ERISA establishes a two-tiered framework enabling a plan participant or beneficiary to assert her right to benefits under the plan. The first avenue of redress consists of internal plan claims procedures. When a plan administrator initially denies a claim for benefits, ERISA requires it to "provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant." 29 U.S.C. 1133(1). The plan must then "afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim." 29 U.S.C. 1133(2).

The second avenue of redress is judicial review of the plan's "wrongful denial of benefits." *Varity Corp.* v. *Howe*, 516 U.S. 489, 512 (1996). A participant whose claim has been denied may bring a civil action "to recover benefits due to him under the terms of his plan." 29 U.S.C. 1132(a)(1)(B). In such a suit, the court "review[s] the decision[] of [the] ERISA plan administrator." *Conkright* v. *Frommert*, 130 S. Ct. 1640, 1646 (2010).

2. Petitioner, an employee of WalMart Stores, Inc. (WalMart), stopped working on June 8, 2005, as a result of several medical conditions. Pet. App. 6. On August 22, 2005, petitioner filed a claim for long-term disability benefits with respondent Hartford Life & Accident Insurance Co. (Hartford), the plan administrator of WalMart's group disability-benefits plan. *Id.* at 7.

Under WalMart's Hartford policy, an employee seeking benefits must provide written "proof of loss" to Hartford within 90 days after the start of the period for which Hartford owes payment or, if it is not possible to provide proof by that date, within one year of the original deadline. Pet. App. 7, 56. The policy further provides that "[l]egal action cannot be taken against [Hartford] * * * sooner than 60 days after due proof of loss has been furnished; or * * * [more than] 3 years after the time written proof of loss is required to be furnished." *Id.* at 56.

In November 2005, Hartford notified petitioner that it did not have sufficient information to make a claim determination. Pet. App. 7, 72-74. On December 8, 2005, the date on which proof of loss was due, see Br. in Opp. 4, Hartford denied petitioner's claim for failure to provide satisfactory proof of loss. Pet. App. 8, 75-79. Hartford also informed petitioner that she had a right to file an internal appeal within 180 days, *id.* at 78, but it later indicated that it would reopen the record, without the need for a formal appeal, if petitioner provided additional information. *Id.* at 8. On November 26, 2007, after petitioner submitted additional medical evidence, Hartford issued its final decision denying petitioner's claim. *Id.* at 9.

3. On November 18, 2010, less than three years after Hartford's final decision, petitioner brought this suit

under Section 1132(a)(1)(B), seeking judicial review of Hartford's denial of her claim. Pet. App. 15. Respondents moved to dismiss the complaint on the ground that petitioner had failed to file suit within the limitations period set forth in the plan, *i.e.*, three years after the deadline for submitting written proof of loss. *Id.* at 5.

The district court granted the motion. Pet. App. 5-18. As relevant here, the court explained that because ERISA does not prescribe a limitations period for benefits claims, the applicable period is the most nearly analogous state statute. *Id.* at 13. Looking to Connecticut law, the court concluded that state law permitted insurance carriers to "contract for a limitations period in which a claim may be filed as long as that period is not less than one year." *Ibid.* Further, the court reasoned, Second Circuit precedent held that a "limitations period that begins to run before a claimant may bring legal action is enforceable." *Ibid.* (citing *Burke* v. *PriceWaterhouseCoopers LLP Long Term Disability Plan*, 572 F.3d 76, 79-81 (2d Cir. 2009) (per curiam)). The court therefore applied the plan's limitations provision and concluded that petitioner's suit was untimely. Although the parties disputed the relevant proof of loss deadline, the court held that the latest that proof of loss was due was September 30, 2007, the date of the extension Hartford had granted in connection with petitioner's internal appeal. *Id.* at 14. Because petitioner had filed suit more than three years after September 30, 2007, the court dismissed the complaint. *Id.* at 15.

4. The Second Circuit affirmed in an unpublished per curiam opinion. Pet. App. 1-4. The court held that "[i]n this Circuit, a statute of limitations specified by an ERISA plan for bringing a claim under 29 U.S.C. [] 1132 may begin to run before a claimant can bring a legal

action." *Id.* at 3 (citing *Burke*, 572 F.3d at 81). The court therefore concluded that petitioner's suit was untimely because she filed it "more than three years after her proof of loss was due." *Ibid.*

SUMMARY OF ARGUMENT

An employee benefits plan governed by ERISA may not prescribe a limitations period for seeking review of the plan's denial of benefits that commences before the plan has made its final decision. Such provisions are inconsistent with ERISA's remedial scheme because they permit the participant's exhaustion of plan remedies—which is mandatory—to consume all or part of the time for seeking judicial review of the plan's final determination. Setting the two statutory avenues of redress against each other in this manner undermines the availability and efficacy of both.

A. ERISA protects employees' entitlement to contractually defined benefits by establishing a comprehensive enforcement scheme. When a plan participant's claim for benefits is initially denied, ERISA provides procedures for relief in two stages: first, an internal plan review process, 29 U.S.C. 1133(2), and then judicial review of the plan's final determination, 29 U.S.C. 1132(a)(1)(B). The internal claims process serves the critical purpose of permitting the parties to resolve disputes efficiently, without resorting to litigation, and it also enables the creation of a full record for those cases in which judicial review becomes necessary. Accordingly, courts have uniformly held that exhaustion of available plan remedies is a prerequisite to seeking judicial review.

B. The limitations period for seeking judicial review under Section 1132(a)(1)(B) begins to run when the plaintiff's cause of action accrues—that is, when the

claimant has exhausted internal plan remedies and the plan administrator has issued its final decision. Under federal common law limitations principles, which govern the time for filing suit under Section 1132(a)(1)(B), the "standard rule" is that the limitations period begins to run when the plaintiff's cause of action has accrued—in other words, when "the plaintiff can file suit and obtain relief." *Bay Area Laundry & Dry Cleaning Pension Trust Fund* v. *Ferbar Corp.*, 522 U.S. 192, 201 (1997). Congress legislated against that background rule in enacting ERISA, and therefore would reasonably have expected it to apply to claims brought under Section 1132(a)(1)(B).

Consistent with the general rule when a plaintiff is required to exhaust administrative or other non-judicial remedies before filing suit, a plaintiff's cause of action under Section 1132(a)(1)(B) accrues when exhaustion of the plan's statutorily mandated review procedures is complete and the plan has issued its final decision. See *Crown Coat Front Co.* v. *United States*, 386 U.S. 503, 514 (1967). Before that point, the plan has not definitively rejected the plaintiff's claim, and she does not "know what claim [she] has or on what grounds administrative action may be vulnerable." *Id.* at 513-514. The statute of limitations for a Section 1132(a)(1)(B) claim therefore commences when the plan finally denies the plaintiff's claim.

C. An ERISA plan may not include terms that purport to deviate from that rule by providing that the limitations period for filing suit in court begins before the claimant has exhausted remedies under the plan's review procedures. Such terms are inconsistent with ERISA's remedial scheme because they undermine the

efficacy of both the internal claims procedures and judicial review.

ERISA's requirement of "full and fair" internal review procedures, 29 U.S.C. 1133(2), is intended to ensure that the plan's final decision is rendered only after a non-adversarial process in which the plan fiduciary has had a meaningful dialogue with the claimant. If the limitations period began to run before exhaustion was complete, the internal claims procedure could consume all or part of a participant's time for preparing and filing a suit challenging the plan's eventual decision. In addition to impeding participants' ability to seek judicial review, the uncertainty about the time for filing suit would encourage participants to attempt to expedite internal review by cutting short interaction with the plan and proceeding in a more truncated and adversarial way. The internal review procedure would thus be less likely to function as an efficient means of resolving claims without litigation. The factual record that resulted would be less developed, thereby hindering judicial review.

Respondents suggest that those concerns could be alleviated through a case-by-case inquiry permitting equitable tolling in the "rare" cases in which the participant is left with an unreasonably short time to file suit. Br. in Opp. 25. But that ad hoc approach would not furnish the clear, predictable rules necessary to avoid distorting the parties' incentives and undermining the remedial framework. It would also create additional burdensome litigation over participants' entitlement to tolling.

D. Respondent's reliance on state laws permitting insurance policies to provide that the limitations period begins to run when proof of loss is due is misplaced. Such laws are inconsistent with ERISA's remedial

framework and therefore cannot supply the federal common law rule of decision. In addition, such statutes are designed to operate in state-law breach-of-contract actions, where exhaustion of non-judicial remedies is not generally required and tying the limitations period to when proof of loss is due does not have adverse consequences.

ARGUMENT

AN ERISA PLAN MAY NOT PROVIDE THAT THE STATUTE OF LIMITATIONS FOR SEEKING JUDICIAL REVIEW OF A PLAN FIDUCIARY'S BENEFITS DETERMINATION BEGINS TO RUN BEFORE THE PLAN FIDUCIARY HAS ISSUED ITS FINAL DECISION

A. ERISA's Comprehensive Remedial Scheme Is Structured To Provide Plan Beneficiaries With Two Complementary And Sequential Avenues—Internal Plan Review And Judicial Review—For Challenging A Plan's Benefits Determination

1. Congress enacted ERISA to "protect * * * participants in employee benefit plans and their beneficiaries" by ensuring that employees receive the benefits they have earned. 29 U.S.C. 1001(b); see *Conkright* v. *Frommert*, 130 S. Ct. 1640, 1648 (2010); *Massachusetts Mut. Life Ins. Co.* v. *Russell*, 473 U.S. 134, 148 (1985) (ERISA "protect[s] contractually defined benefits"). An "essential tool[] for accomplishing" ERISA's protective purposes is its comprehensive enforcement framework. *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 52 (1987); see *Aetna Health Inc.* v. *Davila*, 542 U.S. 200, 208 (2004). That framework is designed to provide employees with "appropriate remedies * * * and ready access to the Federal courts." 29 U.S.C. 1001(b). Specifically, ERISA creates two interlocking procedures for plan

participants seeking benefits under an employee benefits plan: an internal plan claims review mechanism, 29 U.S.C. 1133, and a federal right of action for judicial review of the plan's benefits determination, 29 U.S.C. 1132(a)(1)(B).

When a plan administrator initially denies a claim for benefits, ERISA requires the administrator to provide adequate notice to the participant and to "afford a reasonable opportunity * * * for a full and fair review by the appropriate named fiduciary of the decision denying the claim." 29 U.S.C. 1133. In doing so, the plan must "comply with Department of Labor regulations on * * * affording a reasonable opportunity for review," *Pilot Life*, 481 U.S. at 53, which set "minimum requirements" designed to ensure the fairness and efficacy of the internal claims procedures, 29 C.F.R. 2560.503-1(a). Those statutory and regulatory requirements "underscore[] the particular importance of accurate claims processing," and they "impose[] higher-than-marketplace quality standards on * * * a plan administrator" by requiring it to "'discharge [its] duties' in respect to discretionary claims processing 'solely in the interests of the participants and beneficiaries' of the plan." *Metropolitan Life Ins. Co.* v. *Glenn*, 554 U.S. 105, 115 (2008) (quoting 29 U.S.C. 1104(a)(1)).

A "person denied benefits under an employee benefit plan [may] challenge that denial in federal court." *Glenn*, 554 U.S. at 108; 29 U.S.C. 1132(a)(1)(B). When a plan participant sues to recover benefits allegedly due under the plan, the court "review[s] the decision[] of [the] ERISA plan administrator." *Conkright*, 130 S. Ct. at 1646. That review is ordinarily deferential: when, as is usually the case, plan documents grant the administrator discretion to "determine eligibility for benefits or

to construe the terms of the plan," the plan's determination is reviewed for abuse of discretion. *Ibid.*

2. These two procedures for redress of benefit claims work in conjunction to preserve ERISA's "'careful balancing' between ensuring fair and prompt enforcement of rights under a plan and the encouragement of the creation of such plans." *Davila*, 542 U.S. at 215. Congress provided a right of action to challenge plan benefits decisions because it recognized that "access to the courts" and meaningful judicial review according to uniform standards is critical to plan participants' ability to enforce their rights. H.R. Rep. No. 533, 93d Cong., 1st Sess. 12 (1973) (*House Report*). At the same time, ERISA's requirement of internal claims resolution procedures enables parties to resolve disputes without resorting to costly litigation, and in a more efficient, nonadversarial manner. *Conkright*, 130 S. Ct. at 1649. The internal review procedures also aid any subsequent judicial review by enabling the parties to create a full record and affording the plan administrator an opportunity to apply its expertise in interpreting the plan in the first instance. *Ibid.*; *Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101, 110-111 (1989).

In view of the importance of the plan's internal claims process to the statutory remedial scheme, the courts of appeals have uniformly held that although ERISA does not expressly mandate exhaustion of plan remedies, exhaustion is an "implicit prerequisite" to seeking judicial review under Section 1132(a)(1)(B). *McGraw* v. *Prudential Ins. Co.*, 137 F.3d 1253, 1263 (10th Cir. 1998)[1]; see *LaRue* v. *DeWolff, Boberg & Assoc.*, 552 U.S.

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[1] See also *Madera* v. *Marsh USA, Inc.*, 426 F.3d 56, 61 (1st Cir. 2005); *Burke* v. *Price Waterhouse Coopers LLP Long Term Disability Plan*, 572 F.3d 76, 79 (2d Cir. 2009) (per curiam); *Weldon* v. *Kraft*,

248, 258-259 (2008) (Roberts, C.J., and Kennedy, J., concurring). Similarly, the Labor Department's regulations assume that, absent unusual circumstances such as a plan's failure to provide full and fair procedures, exhaustion is ordinarily required and "claimants would be entitled to have a claim dispute adjudicated in court pursuant to section [1132(a)] of the Act *after* exhausting the plan's claims procedures." 65 Fed. Reg. 70,254 & n.33 (Nov. 21, 2000) (emphasis added); see 29 C.F.R. 2560.503-1(*l*). For instance, the regulations require the plan administrator to provide the claimant with notice of her right to bring suit under Section 1132(a) "following [the] adverse benefit determination *on review*." 29 C.F.R. 2560.503-1(g)(1)(iv) (emphasis added), 2560.503-1(j)(4). They also state that when the plan fails to establish procedures in accordance with the statute and regulations, beneficiaries "shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies under" Section 1132. See 29 C.F.R. 2560.503-1(*l*).

Inc., 896 F.2d 793, 800 (3d Cir. 1990); *Makar* v. *Health Care Corp. of Mid-Atlantic (Carefirst)*, 872 F.2d 80, 83 (4th Cir. 1989); *Bourgeois* v. *Pension Plan for Emps. of Santa Fe Int'l Corps.*, 215 F.3d 475, 479 (5th Cir. 2000); *Weiner* v. *Klais & Co.*, 108 F.3d 86, 90 (6th Cir. 1997); *Doe* v. *Blue Cross & Blue Shield United*, 112 F.3d 869, 873 (7th Cir. 1997); *Wert* v. *Liberty Life Assurance Co.*, 447 F.3d 1060, 1063 (8th Cir. 2006); *Barboza* v. *California Ass'n of Prof'l Firefighters*, 651 F.3d 1073, 1076 (9th Cir. 2011); *Perrino* v. *Southern Bell Tel. & Tel. Co.*, 209 F.3d 1309, 1315 (11th Cir. 2000); *Communications Workers of Am.* v. *American Tel. & Tel. Co.*, 40 F.3d 426, 431 (D.C. Cir. 1994).

B. The Statute Of Limitations For Bringing An Action Under Section 1132(a)(1)(B) Begins To Run When The Claimant Has Exhausted Plan Remedies And The Plan Has Issued Its Final Decision

ERISA does not provide a statute of limitations to govern the time in which a plan participant may file suit under Section 1132(a)(1)(B) to challenge a plan's denial of benefits. As a result, federal common law fills that gap. See *Wallace* v. *Kato*, 549 U.S. 384, 388 (2007). Under well-established principles of federal law, against which Congress legislated in enacting ERISA, the limitations period for seeking judicial review under Section 1132(a)(1)(B) commences when the plaintiff's cause of action accrues—*i.e.*, when the plan issues its final decision denying the claim for benefits.

1. When a federal statute does not provide a limitations period for the cause of action it creates, federal law borrows a limitations period as a matter of federal common law. See *North Star Steel Co.* v. *Thomas*, 515 U.S. 29, 33 (1995). Ordinarily, federal law borrows the most analogous state statute of limitations, unless the state period is inconsistent with federal policy. See *Graham Cty. Soil & Water Conservation Dist.* v. *United States*, 545 U.S. 409, 415 (2005).

Because the plaintiff's cause of action arises under federal law, the "question [of] what limitations *principles* shall govern the borrowed limitations *period* is in the first instance one of federal law, to be decided in accordance with the policies discernible in or imputable to the federal statute for which the state limitations period has been borrowed." *Doe* v. *Blue Cross & Blue Shield United*, 112 F.3d 869, 873 (7th Cir. 1997). The limitations principles applied to a federal cause of action thus must be consistent with the statutory framework,

and courts will borrow state principles only when "their full application would [not] defeat the goals of the federal statute at issue." *Hardin* v. *Straub*, 490 U.S. 536, 539 (1989) (state-law principles interrelated with the length of the state limitations period, such as tolling, are ordinarily borrowed, unless inconsistent with federal policy); see also *West* v. *Conrail*, 481 U.S. 35, 39 (1987) (Court borrows only so much of state limitations law as is necessary to fill gap in federal statute and is consistent with federal policy).

Whether or not a federal statute provides a limitations period, the "standard rule" under federal law is that the statute of limitations does not begin to run until the plaintiff's cause of action has accrued—in other words, when "the plaintiff can file suit and obtain relief." *Wallace*, 549 U.S. at 388; *Bay Area Laundry & Dry Cleaning Pension Trust Fund* v. *Ferbar Corp.*, 522 U.S. 192, 200-201 (1997) (describing this rule as reflecting "basic limitations principles"); *Reiter* v. *Cooper*, 507 U.S. 258, 267 (1993); *Clark* v. *Iowa City*, 87 U.S. (20 Wall.) 583, 589 (1875) ("All statutes of limitation begin to run when the right of action is complete"); see also Horace G. Wood, *Limitations of Actions at Law and at Equity* § 117, at 616 (1916); *id.* § 122a, at 684. That rule reflects the fact that "[i]t would clearly be unfair to charge the plaintiff with the expiration of any time before the plaintiff's cause of action could be prosecuted to a successful conclusion." 1 Calvin W. Corman, *Limitation of Actions* § 6.1, at 370 (1991). Permitting the limitations period to run before the plaintiff can sue could "bar[] [the plaintiff] from the courts," a result that would be "unfortunate" and "untoward." *Crown Coat Front Co.* v. *United States*, 386 U.S. 503, 514-515 (1967). As a result, the Court will not infer that Congress intended the limita-

tions period to commence before the cause of action accrues absent an express indication in the statute. *Reiter*, 507 U.S. at 267 (declining to "infer such an odd result in the absence of any such indication in the statute"); see also *TRW Inc.* v. *Andrews*, 534 U.S. 19, 38 (2001) (Scalia, J., concurring in the judgment) (Congress legislates against this background rule of accrual).

2. Congress enacted ERISA against the backdrop of the traditional rule that the limitations period begins to run when the cause of action accrues. The statute does not expressly provide a different accrual date for Section 1132(a)(1)(B); Congress therefore would reasonably expect that courts would apply standard federal common law limitations principles. See *Wallace*, 549 U.S. at 388 (applying standard accrual rule where Congress did not provide a statute of limitations and state period was borrowed); *TRW Inc.*, 534 U.S. at 38 (Scalia, J., concurring in the judgment) ("When [Congress] has wanted us to apply a different rule * * * it has said so."); *Reiter*, 507 U.S. at 267. Thus, although the limitations period for Section 1132(a)(1)(B) claims is borrowed from state law, *Burke*, 572 F.3d at 78, federal law provides that the time to sue under Section 1132(a)(1)(B) begins running when the plaintiff is first able to file suit in court. See *Bay Area Laundry*, 522 U.S. at 201.

A plaintiff's Section 1132(a)(1)(B) claim for judicial review of the plan's denial of benefits accrues when she has exhausted internal remedies and the plan has made its final determination. Plan participants are required to exhaust the plan's internal remedies, and the Section 1132(a)(1)(B) action is one for judicial review of the plan's final decision, rather than a de novo action for benefits. See pp. 9-10, *supra*; *Metropolitan Life Ins. Co.* v. *Taylor*, 481 U.S. 58, 66 (1987) ("the civil enforcement

section * * * enable[s] participants and beneficiaries to bring suit to recover benefits denied contrary to the terms of the plan"). When "disputes are subject to mandatory administrative proceedings" before the plaintiff may resort to court, and the purpose of the suit is to obtain judicial review of the final result of the pre-suit proceedings, the general rule is that "the claim does not accrue until their conclusion." *United States* v. *Meyer*, 808 F.2d 912, 916 (1st Cir. 1987) (citation omitted); see *Crown Coat Front*, 386 U.S. at 513-514 (rejecting argument that cause of action for judicial review of administrative decision should accrue before completion of required administrative proceedings). That rationale behind the accrual rule applies with full force to ERISA claims. Before a plan participant has completed the required exhaustion, her "claim is not subject to adjudication in the courts." *Id.* at 511. The Section 1132(a)(1)(B) claim challenges the "wrongful denial of benefits," *Varity Corp.* v. *Howe*, 516 U.S. 489, 512 (1996), and no final and actionable denial has occurred before the plan administrator has rejected the participant's claim at the conclusion of the internal review process. Nor, prior to that time, can the claimant "know what claim he has or on what grounds administrative action may be vulnerable." *Crown Coat Front*, 386 U.S. at 513-514.

As a result, the governing rule under ERISA is that a plan participant's Section 1132(a)(1)(B) claim for benefits does not accrue until the participant has exhausted the plan's internal procedures and the plan has rendered the final decision that will be reviewed by the court.[2]

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[2] Consistent with this rule, in cases involving a plaintiff's challenge to a plan's denial of her application for benefits, the courts of appeals have generally held that a Section 1132(a)(1)(B) claim accrues when

See *Bay Area Laundry*, 522 U.S. at 201; see also, *e.g.*, *Wise* v. *Verizon Commc'ns, Inc.*, 600 F.3d 1180, 1188-1189 (9th Cir. 2010); *Martin* v. *Construction Laborer's Pension Trust*, 947 F.2d 1381, 1385-1386 (9th Cir. 1991).

C. An ERISA Plan May Not Provide That The Limitations Period Begins To Run Before The Plaintiff's Claim Accrues

1. Plan provisions governing the limitations period for seeking review of a plan's claim denial must be consistent with ERISA's remedial scheme

The question presented in this case is whether an ERISA plan may deviate from the limitations-accrual rule that governs in a suit under Section 1132(a)(1)(B) by providing that the limitations period for seeking judicial review begins to run before the participant has exhausted plan remedies, and before her cause of action for judicial review has accrued. The answer to that question turns on whether permitting a plan to uncouple the commencement of the limitations period from the accrual of the cause of action would be consistent with the policies embodied in ERISA.

The extent to which private parties may alter the governing limitations rules is, like other questions concerning the statute of limitations for a federal claim, a matter of federal common law that must be "decided in accordance with the policies discernible in" the underly-

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the plan makes its final decision on the plaintiff's claim, a rule sometimes expressed as requiring a "clear and continuing repudiation" by the plan of the plaintiff's claim. See, *e.g.*, *Withrow* v. *Halsey*, 655 F.3d 1032, 1036 (9th Cir. 2011); *Daill* v. *Sheet Metal Workers' Local 73 Pension Fund*, 100 F.3d 62, 67 (7th Cir. 1996); *Martin* v. *Construction Laborer's Pension Trust*, 947 F.2d 1381, 1386 (9th Cir. 1991).

ing federal statute. *Doe*, 112 F.3d at 873; see pp. 12-13, *supra*. Thus, although "a provision in a contract may validly limit, between the parties, the time for bringing an action on such contract to a period less than that prescribed in the general statute of limitations," the parties may agree to deviate from governing limitations rules only "in the absence of a controlling statute to the contrary." *Order of United Commercial Travelers of Am.* v. *Wolfe*, 331 U.S. 586, 608 (1947).

ERISA's structure demonstrates that plan terms that purport to govern a participant's ability to enforce her claim to benefits must be consistent with the statutory remedial scheme. While ERISA gives employers broad discretion to determine whether to offer employee benefits plans and what benefits to provide, see *Curtiss-Wright Corp.* v. *Schoonejongen*, 514 U.S. 73, 78 (1995), the Act closely regulates the enforcement of contractually defined benefits by establishing an "interlocking, interrelated, and interdependent remedial scheme." *Massachusetts Mut. Life Ins. Co.* v. *Russell*, 473 U.S. 134, 146, 148 (1985). That remedial scheme is designed to guarantee "ready access to the Federal courts," 29 U.S.C. 1001(b), and to eliminate "jurisdictional and procedural obstacles which in the past appear to have hampered effective enforcement of fiduciary responsibilities," *House Report* 17. The reticulated nature of ERISA's civil enforcement provisions has led this Court to decline to "tamper with [the] enforcement scheme" by supplementing it with additional state or federal avenues of relief. *Pilot Life*, 481 U.S. at 54.

As a result, ERISA—not the plan—ultimately controls the claimant's right to judicial review under Section 1132(a)(1)(B). For instance, a plan provision purporting to exempt the plan administrator from liability

for suits brought under Section 1132(a)(1)(B) would be void, because it would be inconsistent with Congress's determination that ERISA's remedial provisions are necessary to protect employee interests. 29 U.S.C. 1110(a) ("any provision in an agreement or instrument which purports to relieve a fiduciary from responsibility or liability for any responsibility, obligation, or duty under this part shall be void as against public policy"); cf. 29 U.S.C. 1104(a)(1)(D) (fiduciary must perform its duties "in accordance with" plan terms, "insofar as such documents and instruments are consistent with the provisions of this subchapter"); *House Report* 12 (explaining that pre-ERISA state trust law was insufficiently protective because it permitted trust documents to exempt trustees from certain legal duties). Similarly, although plans have leeway in structuring their internal claims processes, those procedures must be "full and fair," 29 U.S.C. 1133(2), and they must comply with the minimum requirements set forth in the Labor Department's regulations, 29 C.F.R. 2560.503-1. Any plan terms that purport to govern the internal-review process or the plan participant's access to judicial review must therefore be consistent with ERISA's remedial structure and the Secretary's implementing regulations.[3]

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[3] This Court's holding in *U.S. Airways, Inc.* v. *McCutchen*, 133 S. Ct. 1537 (2013)—that the defenses available in an action to enforce a plan's reimbursement provision are governed by the terms of the plan—is not to the contrary. There, the health plan brought suit under Section 1132(a)(3), which authorizes suits for "appropriate equitable relief * * * to enforce * * * the terms of the plan," seeking to enforce a provision entitling the plan to reimbursement of benefits paid when the beneficiary recovers damages from a third-party tortfeasor. The Court held that the plan's suit was analogous to an action to enforce an "equitable lien by agreement." *Id.* at 1546. Because

2. *Plan terms providing that the limitations period begins to run before the plaintiff's claim has accrued are inconsistent with ERISA's remedial scheme*

An ERISA plan cannot lawfully provide that the limitations period commences on the date the participant must provide proof of loss—*i.e.*, early in the plan review process, well before the participant may seek judicial review. Such a provision is inconsistent with ERISA's two-tiered remedial scheme because it sets the two procedures for redress—internal claims processes and judicial review—against each other, thereby undermining the availability and efficacy of both.

a. Plan terms that trigger the limitations period before the internal plan process is complete risk substantially shortening or even consuming the time for the plaintiff to seek judicial review of the plan's final decision. "[E]very day the plan took for its decision-making would be one day less that a claimant would have to review the plan's final decision, decide whether to challenge it in court, and prepare a civil action if need be." *White* v. *Sun Life Assurance Co.*, 488 F.3d 240, 247-248 (4th Cir.), cert. denied, 552 U.S. 1022 (2007). That odd result would give "[b]enefit plans * * * the incentive to delay the resolution of their participants' claims." *Id.* at 427. The more significant concern, however, is that

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such a suit traditionally sought to enforce the terms of the agreement, and "[t]he agreement itself [became] the measure of the parties' equities," the Court held that the plan's terms, not general equitable principles of unjust enrichment, governed the parties' rights. *Id.* at 1548. That holding was based on the principles applicable to the most analogous action in equity, rather than any conclusion that plans may limit or regulate the judicial remedies provided by ERISA. The Court did not suggest that plans may override ERISA's judicial-review provisions or limit a claimant's right to bring a Section 1132(a)(1)(B) suit.

plan administrators acting in good faith would consume the limitations period: the internal review process is intended to be an iterative one, in which a "meaningful dialogue" between plan and participant fosters more accurate, equitable results. *Booton* v. *Lockheed Med. Benefit Plan*, 110 F.3d 1461, 1463 (9th Cir. 1997) (citing regulations).

Conducting the internal claims process in the manner intended by Congress would therefore encroach on the time for seeking judicial review under the limitations imposed by the plan. Although respondents argue (Br. in Opp. 23) that the Secretary's claims-processing regulations assuage that concern by "strictly limit[ing] the amount of time a plan administrator has to make an initial benefits determination and decide an administrative appeal," the regulatory time periods are in fact designed to be flexible in order to encourage full and thorough internal consideration. Most importantly, the regulations permit plan administrators to toll the applicable time limits for potentially extended periods by requesting more information from the claimant. 29 C.F.R. 2560.503-1(f)(4). By way of illustration, in this case Hartford claims to have complied with the regulatory time limits by issuing a final decision on petitioner's claim 718 days, or nearly two years, after her proof of loss was due. See Br. in Opp. 4-6. And even in the absence of authorized tolling, the regulations permit a group benefits plan to take up to 345 days to issue its final decision: the plan could in appropriate circumstances take 75 days to make its initial determination concerning a disability benefits claim, 29 C.F.R. 2560.503-1(f)(3), must permit the claimant *at least* 180 days to file an internal appeal, 29 C.F.R. 2560.503-1(h)(3)(i), and could take up to 90 days to decide the

appeal, 29 C.F.R. 2560.503-1(i)(1)(i) and (3)(i). The internal claims process thus may often entirely consume, or materially shorten, the time in which the plaintiff may seek judicial review.

That result is directly contrary to ERISA's reliance on judicial enforcement as a crucial means of ensuring that the plan's decision is reasonable and was reached after full and fair procedures. See *Davila*, 542 U.S. at 208; *Conkright*, 130 S. Ct. at 1649. When a statute "evidences a congressional purpose to insure adequate judicial review of [internal] decisions," as ERISA does, "it is very doubtful that [Congress] anticipated no review at all if administrative proceedings, compulsory on the [participant], continued for" longer than the limitations period. *Crown Coat Front*, 386 U.S. at 514 (holding that permitting limitations period to commence before conclusion of administrative procedures could thwart judicial review, which "is not an appealing result, nor * * * one that Congress intended"); see also *Varity Corp.*, 516 U.S. at 513 (ERISA is designed to develop "a sensible administrative system").

Even when the internal review proceedings do not consume the entire limitations period, a participant may face a substantially shortened time in which to prepare to file suit. Before the plan has issued its final decision, the participant does not know whether she will need to file suit, or whether, if the plan denies her claim, she will have viable arguments to make in court. A plaintiff therefore cannot begin preparing her lawsuit before the plan has issued its final decision. While a plaintiff might attempt to mitigate this risk by filing a protective declaratory-judgment action for benefits, see 29 U.S.C. 1132(a)(1)(B), she cannot "sensibly ask the courts to review a decision which has not yet been made," and

such premature suits would likely serve only to create procedural complications and additional litigation. *Crown Coat Front*, 386 U.S. at 515.

b. Subjecting plan participants to uncertainty about their ability to prepare for and seek judicial review would also undermine the efficacy of the plan's internal procedures. Section 1133(2)'s requirement that a plan provide "full and fair review" procedures and the regulations implementing that requirement are designed to ensure that the plan's final benefits decision is based on a meaningful, thorough, and non-adversarial exchange between the plan fiduciary and the claimant. *Booton*, 110 F.3d at 1463. Permitting plans to provide that the limitations period runs during the plan's internal claims process would create perverse incentives for beneficiaries: any dialogue with plan fiduciaries about the merits of their claim might eat into the time to seek court review of a final decision. Beneficiaries might therefore seek to cut short exchanges with plan administrators, or treat the process in a more adversarial manner, in the hope of preserving adequate time to seek judicial review. Claimants might also feel compelled to hire attorneys earlier in the process, and in more cases. These consequences would vitiate the purposes served by internal review proceedings—the same purposes that have led courts to require exhaustion of these proceedings. See pp. 10-11, *supra*. Fewer claims would be resolved without litigation; plan administrators' ability to resolve claims accurately in the first instance would be hindered; and the factual record on which judicial review must be conducted would be less complete. Those ad-

verse consequences would in turn undermine the efficacy of judicial review.[4]

Permitting the limitations period to commence at the outset of the plan's internal review process would also work at cross-purposes to the Secretary's claims-processing regulations. The purpose of permitting plan administrators to toll the regulatory time limits by requesting more information is to enable dialogue between plan and participant, see 65 Fed. Reg. at 70,250, but that purpose would be defeated by the incentives created by respondents' rule. That regulation's tolling provisions should not be permitted to threaten beneficiaries' ability to seek judicial review. In addition, although the regulations entitle a beneficiary to at least 180 days to appeal a group health plan's initial adverse benefits determination, 29 C.F.R. 2560.503-1(h)(3)(i), respondents' rule would likely cause beneficiaries to forgo some of that time in an attempt to protect their ability to seek judicial review. That would be contrary to the Department's conclusion that 180 days strikes the appropriate balance between the participant's need for adequate time to prepare the appeal and the plan's interest in expeditiously resolving benefits claims.

c. Finally, permitting an ERISA plan to uncouple the commencement of the limitations period from claim accrual would be inconsistent with principles of trust

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[4] When an ERISA plan contains a provision that shortens the otherwise-applicable state limitations period, but does not provide that the limitations period begins to run before the claim has accrued, the beneficiary is not subjected to these uncertainties or forced into the dilemma that undermines the efficacy of the remedial scheme. Thus, although the question is not presented here, provisions that simply shorten the limitations period following the plan's issuance of its final decision, if reasonable, may be consistent with ERISA and therefore permissible. See *White*, 488 F.3d at 250.

law, which provides guidance in interpreting ERISA. *Varity Corp.*, 516 U.S. at 496-497 (Congress drew on trust law in enacting ERISA). In establishing a trust, the settlor has broad discretion to determine the purpose and terms of the trust. But the settlor may not include terms that purport to deprive the court of jurisdiction to review the trustee's actions. See Unif. Trust Code § 105 (2000, last revised or amended 2010); Alan Newman, George G. Bogert & George T. Bogert, *The Law of Trusts and Trustees* § 961, at 1-2 (3d ed. 2010) (Bogert). Relatedly, the settlor may not relieve the trustee of its duty to provide an accounting of its management of the trust property to the beneficiary, because the right to an accounting is critical to the beneficiary's ability to discover potential claims against the trustee and to enforce them in court. Bogert § 965, at 111-119. Here, the internal claims procedure required by ERISA is analogous to a trust accounting, in the sense that the ERISA participant cannot know whether she has a judicial claim against the plan, and on what grounds, until she has exhausted the internal procedure and received the plan's final determination.

The limitations period for a breach-of-trust claim does not commence until the beneficiary's cause of action has accrued—namely, when "the trust is closed, or * * * the trustee * * * disavows the trust, or *holds adversely to the claim of those he represented.*" *Bacon* v. *Rives*, 106 U.S. 99, 107 (1882) (emphasis added). Specifically, the Uniform Trust Code provides that the limitations period ordinarily begins to run when the beneficiary receives a report containing an accounting that reveals the existence of a potential claim—by analogy, the point at which an ERISA plan issues its final decision on a benefits claim. Bogert § 965, at 137 (citing

Unif. Trust Code § 1005); see, *e.g.*, Mich. Comp. Laws Ann. § 700.7905 (West 2010); Fla. Stat. Ann. § 736.1008 (West 2008). Permitting ERISA plans to provide a pre-exhaustion limitations-period commencement date would thus be inconsistent with the limitations principles that apply in the trust context and with the constraints on settlors' ability to curtail judicial review.

3. Respondents' proposed case-by-case reasonableness approach would not mitigate the adverse consequences of the plan's limitations provision

Respondents contend that the adverse effects of allowing the statute of limitations to begin running while the claimant pursues internal plan remedies can be addressed by "a case-by-case inquiry into the reasonableness of the limitations period and by application of equitable tolling." Br. in Opp. 23-24; *id.* at 12 (citing cases that endorsed this approach); see *Burke*, 572 F.3d at 81 n.5 (court has authority to determine the reasonableness of and toll limitations period provided in ERISA plan). But the reason that tying the limitations period to proof of loss is inconsistent with ERISA's remedial scheme is that it creates timing uncertainties that distort the parties' incentives and undercut the two-tiered remedial structure. The ad hoc tolling approach respondents advocate would not address that fundamental problem; instead, it would introduce additional uncertainties and result in increased litigation.

Importantly, respondents' case-by-case tolling approach is not a categorical rule that would toll the limitations period during the pendency of plan proceedings in every case. Br. in Opp. 12, 21-22. State courts have sometimes applied a categorical tolling rule to insurance policies that start the limitations period on insurance claims before the conclusion of insurer-imposed prereq-

uisites to suit. See pp. 30-31, *infra*. Unlike that practice under state law, respondents' proposed inquiry would entail an after-the-fact examination of case-specific factors to evaluate whether it would be equitable to enforce the limitations period against a plan participant who brings an untimely claim. Br. in Opp. 12; *Rice* v. *Jefferson Pilot Fin. Ins. Co.*, 578 F.3d 450, 455-456 (6th Cir. 2009). While there presumably would be easy cases at either extreme—where exhaustion either entirely consumed the plaintiff's time to bring suit, or left her with multiple years in the limitations period—the availability of tolling in the many cases between these poles would be considerably less clear. The court would likely have to consider factors such as the amount of time left in the limitations period after exhaustion, the complexity of the plaintiff's claims and the amount of time reasonably necessary to prepare a suit involving those claims, the participant's awareness (or lack thereof) of the running of the limitations period, the diligence with which the participant pursued plan remedies and filed suit, whether the plan was engaged in "a subterfuge to prevent lawsuits," and any other relevant circumstances. *Northlake Reg'l Med. Ctr.* v. *Waffle House Sys. Emp. Benefit Plan*, 160 F.3d 1301, 1304 (11th Cir. 1998); see *White*, 488 F.3d at 259 (Wilkins, C.J., dissenting).

This case-specific approach would leave both parties unable to discern, when the participant initiates her claim, how the limitations period will be enforced in her case. Plans would thus be unable to apprise beneficiaries *ex ante* how much time they will have to file suit and whether an untimely filing might be excused by the courts. See *White*, 488 F.3d at 248-249. That uncertainty is inconsistent with the statutory notice requirements, which are intended to ensure that "every em-

ployee may, on examining the plan documents, determine exactly what his rights and obligations are under the plan." *Curtiss-Wright Corp.*, 514 U.S. at 83 (emphasis omitted); see 29 U.S.C. 1102(a)(1) (requiring plan to be "maintained pursuant to a written instrument").

Given the case-specific nature of the tolling approach, moreover, beneficiaries would have to proceed on the assumption that they will not be entitled to tolling, lest they forfeit their ability to obtain judicial review. The theoretical availability of equitable tolling would therefore not meaningfully alter the perverse incentives created by the pre-exhaustion limitations-period trigger date. Beneficiaries would still be well-advised to expedite the internal process as much as possible. See pp. 22-23, *supra*.

Respondents' rule would also undermine ERISA's objectives by spawning burdensome litigation over the reasonableness of truncated limitations periods, the appropriateness of equitable tolling, and the adequacy of notice. See *Conkright*, 130 S. Ct. at 1649-1650 (discussing ERISA's policy of avoiding "costly litigation"). Given the fact-specific nature of the inquiry, courts would likely come to differing results, even with respect to similarly situated beneficiaries of the same ERISA plan. That is directly contrary to ERISA's goal of fostering "a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred." *Rush Prudential HMO, Inc.* v. *Moran*, 536 U.S. 355, 379 (2002).

D. Respondents' Reliance On State Contract Law Is Misplaced

In contending that ERISA plans may provide that the limitations period begins to run well before the

plaintiff may sue, respondents rely on state statutes that permit insurers to insert such provisions in their policies. Br. in Opp. 21-22. Connecticut law, for instance, requires individual disability insurance policies to include a provision stating that an action shall be brought no later than three years after proof of loss must be furnished, and permits group policies to include such a provision. *Ibid.*; see Conn. Gen. Stat. Ann. § 38a-483(a)(11) (West 2010). The existence of such statutes, however, does not suggest that that rule should apply to claims brought under ERISA. State-law rules governing the point at which the statute of limitations begins to run do not apply of their own force to federal causes of action; rather, the courts must decide whether to borrow them as a matter of federal common law. Doing so would be appropriate only if the state-law rule were consistent with the policies animating the federal statute—and that is not the case here.[5] See pp. 16-18, *supra*; see also *Wolfe*, 331 U.S. at 608 (stating that contracting parties may adopt a reasonable limitations period shorter than the "general" period "in the absence of a controlling statute to the contrary").

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[5] Respondent does not contend that, by virtue of the insurance savings clause in ERISA's preemption provision, 29 U.S.C. 1144(b)(2)(A), state law required it to include a provision in its policy that the limitations period begins to run from when proof of loss must be filed. Although the question therefore is not presented here, a state statute that did require such a provision in a plan subject to ERISA would likely be preempted. Cf. *Pilot Life*, 481 U.S. at 52 (explaining that Congress intended to provide an exclusive federal civil enforcement framework for ERISA claims); *Chamber of Commerce* v. *Whiting*, 131 S. Ct. 1968, 1979-1985 (2011) (notwithstanding savings clause preserving certain state laws from express preemption, state law might still be preempted if it conflicted with federal law).

Looking to state laws like Connecticut's for guidance on whether ERISA plans may move up the limitations commencement date would be particularly inappropriate because such statutes are designed to operate in a context that is very different from ERISA: state-law insurance claims, which generally involve no required exhaustion of plan remedies. See *West*, 481 U.S. at 39 (applying state service rule to borrowed state limitations period was inappropriate because "the borrowed statute is to be applied in a context somewhat different from the one in which those [state] procedural rules originated"). A state-law action for benefits allegedly due under an insurance policy is a standard breach-of-contract action adjudicated de novo by the court. See, *e.g.*, *Parrot* v. *Guardian Life Ins. Co.*, 866 A.2d 1273, 1275 (Conn. 2005); *Allstate Ins. Co.* v. *Spinelli*, 443 A.2d 1286, 1292 (Del. 1982). State law generally does not require the plaintiff to have first exhausted any internal remedies the insurer may provide, and the court adjudicates the plaintiff's claim in the first instance, rather than reviewing the insurer's denial of benefits under a deferential standard. See, *e.g.*, *LaPerla, Ltd.* v. *Peerless Ins. Co.*, 980 A.2d 971, 975 (Conn. Super. Ct. 2009). As a result, the plaintiff need not await the conclusion of any internal plan review process before her cause of action accrues. In addition, the contractual nature of the suit reflects the fact that, unlike in the ERISA context, the relationship between insured and insurer is not a fiduciary one based in trust law.[6] See, *e.g.*, *Tucker* v. *State*

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[6] The contractual relationship between insured and insurer does implicate an implied duty of fair dealing. A claim for breach of that duty does not accrue until the insurer has unreasonably denied the claim. *Murray* v. *San Jacinto Agency, Inc.*, 800 S.W.2d 826, 829 (Tex. 1990).

Farm Mut. Auto. Ins. Co., 53 P.3d 947, 951-952 (Utah 2002).

Some policies, like Hartford's, provide a waiting period (usually 60 or 90 days after proof of loss is due) during which the insured may not file suit. See Lee R. Russ, *Couch on Insurance 3d* § 236:167, at 236-133 (2000) (*Couch*); Br. in Opp. 3. But after the conclusion of that period, the insured may sue, whether or not the insurer has responded to her demand for payment. See, *e.g.*, *Terry* v. *UNUM Life Ins. Co.*, 394 F.3d 108, 110 (2d Cir. 2005) (per curiam). Thus, although the cause of action may not accrue until the conclusion of the waiting period, see *Millstone* v. *St. Paul Travelers*, 962 A.2d 432, 439 (Md. Ct. Spec. App. 2008), which is after the limitations period has begun to run, the date on which the plaintiff may file her state-law suit does not depend on any action by the insurer. Uncoupling the commencement of the limitations period from the accrual of the claim therefore does not create the uncertainty and conflicting incentives that it does in the ERISA context. In addition, the purpose of state laws permitting insurers to provide a shortened limitations period that runs from the date of proof of loss—to give the insurer certainty about the time for suit and extent of its exposure, and to guard against false claims, *Prudential-LMI Commercial Ins.* v. *Superior Court*, 798 P.2d 1230, 1241-1242 (Cal. 1990)—is already served in the ERISA context by the exhaustion requirement, which provides the plan administrator with notice of the claim and an opportunity to investigate and compile a record.

Moreover, state courts have often refused to apply policy provisions purporting to govern the commencement of the limitations period in a way that allows much of the limitations period to run before the plaintiff can

file suit. Thus, some courts have held that the limitations period should be tolled in all cases during the waiting period, and others have treated the limitations period as beginning to run at the conclusion of the waiting period. See *Couch* § 236:173, at 236-138 to 236-139 & n.55 (citing cases). In addition, when an insurance policy, instead of providing a waiting period, requires an insured to exhaust certain non-judicial procedures, some courts have held that the limitations period is always tolled during the pendency of those proceedings. See, *e.g.*, *Prudential-LMI Commercial Ins.*, 798 P.2d at 1241 (applying tolling where policy provided that limitations period began to run before insured filed notice of claim, and stating that "the purpose of a shortened limitation period was to obtain the advantage of an early trial of the matters in dispute * * * not to achieve a technical forfeiture of the insured' rights"); *Peloso* v. *Hartford Fire Ins. Co.*, 267 A.2d 498 (N.J. 1970); *Couch* §§ 236:6-236:7, at 236-19 ("it would be unconscionable to permit the time for suit to be consumed in pursuing the specified remedies"); but cf. *Boyce* v. *Allstate Ins. Co.*, No. CV 90-0374599, 1994 WL 9956 (Conn. Super. Ct. 1994) (rejecting equitable tolling where limitations period and 60-day waiting period were provided by statute, but holding that equitable estoppel was available if insurer's investigation consumed limitations period).

Thus, if respondents were correct that state laws permitting insurers to uncouple the limitations period from the point at which the plaintiff is able to sue should be adopted as the federal rule for ERISA claims, there would be a substantial argument that under many States' tolling rules, the limitations period should be tolled—in all cases, not only "rare" cases, as respondents propose (Br. in Opp. 25)—while the plaintiff ex-

hausts the plan's internal review procedures. See *Hardin*, 490 U.S. at 539 (if consistent with the federal statute, state tolling rules ordinarily apply to a borrowed state limitations period). Given that tolling principles are designed to mitigate limitations rules that would be unduly harsh in particular circumstances, the need to toll the limitations period in every case under respondents' approach reinforces the conclusion that plans should not be permitted to deviate from the general federal rule, applicable to ERISA, that the limitations period begins to run when the plan issues its final decision.

CONCLUSION

The judgment of the court of appeal should be reversed.

Respectfully submitted.

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AMICUS CURIAE BRIEF

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In The Supreme Court of the United States

JULIE HEIMESHOFF,

Petitioner,

v.

HARTFORD LIFE & ACCIDENT INSURANCE CO. AND WAL-MART STORES, INC.

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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INTERESTS OF AMICI CURIAE[1]

AARP is a nonprofit, nonpartisan organization, with a membership that helps people turn their goals and dreams into real possibilities, seeks to strengthen communities and fights for the issues that matter most to families such as healthcare, employment and income security, retirement planning, affordable utilities and protection from financial abuse. In its efforts to foster the economic security of individuals as they age, AARP seeks to increase the availability, security, equity, and adequacy of public and private pension, health, disability and other employee benefits which countless members and older individuals receive or may be eligible to receive.[2]

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[1] In compliance with Rule 37 of this Court, counsel for amici state that no counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than amici, its members, or its counsel made a monetary contribution to the preparation or submission of this brief. Counsel of record for all parties received notice at least 10 days prior to the due date of the intention to file this brief. The parties have consented to the filing of this brief.

[2] AARP and the National Employment Lawyers Association have, jointly and singly, participated as amicus curiae in this Court to protect the rights of workers and their beneficiaries under ERISA. *See, e.g., U.S. Airways, Inc. v. McCutchen*, 133 S. Ct. 1537 (2013); *CIGNA Corp. v. Amara*, 131 S. Ct. 1866 (2011); *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008); *Black & Decker Disability Plan v. Nord*, 538 U.S. 822 (2003); *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989).

The National Employment Lawyers Association (NELA) is the largest professional membership organization in the country comprised of lawyers who represent workers in labor, employment and civil rights disputes. Founded in 1985, NELA advances employee rights and serves lawyers who advocate for equality and justice in the American workplace. NELA and its 68 circuit, state, and local Affiliates have a membership of over 3,000 attorneys who are committed to working on behalf of those who have been illegally treated in the workplace. NELA's members litigate daily in every circuit, affording NELA a unique perspective on how the principles announced by the courts in employment and benefit cases actually play out on the ground. NELA strives to protect the rights of its members' clients, and regularly supports precedent-setting litigation affecting the rights of individuals in the workplace, including through cases to protect employee benefits.

Participants in private, employer-sponsored employee benefit plans rely on ERISA to protect their rights under those plans. See Title I – Protection of Employee Benefit Rights, 29 U.S.C. §§ 1001-1191(c). In particular, ERISA's protections, and plan participants' opportunities to enforce the statute's protections, are of vital concern to workers of all ages and to retirees, since the quality of their lives depends heavily on their eligibility for and the amount of their retirement and welfare benefits.

In order to ensure that they are receiving the benefits to which they are entitled, participants must be able to successfully access and resolve benefits

disputes through ERISA's claims procedures. In particular, participants must know the deadline to file a lawsuit if they have been unable to successfully resolve a dispute with their plan over the eligibility for and amount of benefits. If claimants miss the deadline for filing suit because there is no bright line for determining that deadline, they cannot adequately protect their claims to benefits. This may spell the difference between filing for bankruptcy or not. For example, with $768 as the median weekly earning of a fulltime worker, *see* U. S. Dep't of Labor, *Labor Force Statistics from the Current Population Survey: Table 37*, Bureau of Labor Statistics (last modified Feb. 5, 2013), http://www.bls.gov/cps/cpsaat37.htm), and a replacement percentage of sixty percent, see America's Health Ins. Plans (AHIP), *Disability Insurance: A Missing Piece in the Financial Security Puzzle*, 27 (Oct. 2004), http://www.ahipresearch.org/PDFs/27_AHIPDIChartBook.pdf, a disability claimant would receive the modest amount of approximately $460 per week.[3]

The Court's ruling in this case will apply to ERISA benefit claims of all kinds – pension and retirement benefits, health, life insurance, and other welfare benefits in addition to disability benefits –

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[3] For participants at retirement age, even a modest increase in benefit amounts may spell the difference between independence and impoverishment in old age. U.S. Dep't of Commerce, *Preliminary Estimate of Weighted Average Poverty Thresholds for 2012*, U.S. Census Bureau (Jan. 18, 2013), http://www.census.gov/hhes/www/poverty/data/threshld/index.html (2012 poverty threshold for a single person age 65 or older is about $11,000).

and thus resolution of the issues in this case will have a direct and vital bearing on plan participants' ability to protect their claims concerning their benefits. In light of the significance of the issues presented by this case, AARP and NELA respectfully submit this brief, as amici curiae, to facilitate a full consideration by the Court on the issue of the accrual of a benefit claim prior to the completion of the judicially created mandatory requirement of the exhaustion of the plan's internal claims procedure.

SUMMARY OF ARGUMENT

In *U.S. Airways, Inc. v. McCutchen*, 133 S. Ct. 1537, 1546-49 (2013), this Court reaffirmed that clear plan terms are enforceable. However, this rule is of no help in this case because the plan term at issue does not address the question certified by the court. Thus, an implied term is necessary to make the plan term surrounding the limitations period workable. So, this case presents this Court with the question of which implied term to read into Respondent's long-term disability ERISA plan.[4] Respondent urges the

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[4] Although amici acknowledge that this case has been presented to the Court as one arising under a contract, *see Mertens v. Hewitt Assocs.*, 508 U.S. 248, 253-55 (1993) ("we decide this case on the narrow battlefield the parties have chosen"), we question whether this is appropriate given that ERISA actions for benefits are equitable in nature and are subject to the rules that govern equity courts, which generally will not apply a limitations period to a beneficiary's action to enforce the terms of an express trust absent a showing of prejudice to defendant. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110 (1989); *Adams v. Cyprus Amax Minerals Co.*, 149 F.3d 1156, 1160-61 (10th Cir. 1998) (§ 502(a)(1)(B) "claims are

Court to adopt a term requiring that the time from cause of action accrual to the expiration of the contractual limitations must be "reasonable" under all the facts and circumstances of a particular case. As a secondary argument, Petitioner urges the Court to adopt a term tolling of the contractual limitations period during the time a claimant is unable to bring suit because of mandatory claims exhaustion.

Amici agrees with Petitioner's alternative argument. A tolling provision is the far better implied term because it provides a bright line test, is fair to all parties, and facilitates ERISA's goal of providing a thoughtful, full, fair and frank exchange of information and a complete dialogue between them. *See Abram v. Cargill, Inc.*, 395 F.3d 882, 886 (8th Cir. 2005).

Reading a "reasonableness" term into the contract, on the other hand, requires trial courts to determine the contours of a new road and the standards to apply to this reasonableness. Most often, reasonableness will depend on a thorough (and largely pointless) examination of the facts of each case, including which party was responsible for the delay, whether there was good faith, bad faith or, more likely, inappropriate manipulation of the system. Amici suggest that with the continuing reduction of already limited judicial resources, such examinations are not time well spent as it serves no

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fundamentally equitable in nature," and "analogous to a trust action."); *Wardle v. Cent. States Pension Fund*, 627 F.2d 820, 829 (7th Cir. 1980) ("suits for pension benefits by disappointed applicants are equitable" in character).

worthwhile public policy. *See, e.g.*, Admin. Office of the U.S. Cts., *Federal Judiciary Braces for Broad Impact of Budget Sequestration*, The Third Branch News (March 12, 2013), http://news.uscourts.gov/federal-judiciary-braces-broad-impact-budget-sequestration; Admin. Office of the U.S. Cts., *Survey Shows Impact of Reduced Resources*, The Third Branch News (June 04, 2012), http://news.uscourts.gov/survey-shows-impact-reduced-resources; *see also* Amy Covert & Aaron Feuer, *View From Proskauer: The Supreme Court to Opine on Use of Contractual Limitation Periods in ERISA Plans*, Bloomberg Law (2013), http://about. bloomberglaw.com/practitioner-contributions/the-supreme-court-to-opine-on-use-of-contractual-limitation-periods-in-erisa-plans/ ("The Fourth Circuit refused to adopt a case-by-case, fact-intensive assessment of the reasonableness of the accrual provision.").

ARGUMENT

Amici contend that the Court will have to choose to rewrite the plan by adding an implied term to the plan – choosing either a "reasonableness" provision or a "bright line" provision. Between the two provisions at issue, the narrower alternative and the one far more consistent with other ERISA specifications, *see, e.g.*, *infra* at 21-23, is the bright line rule which tolls the statute of limitations so that the mandatory exhaustion of the internal claims procedure may be completed. *See generally Reiter v. Cooper*, 507 U.S. 258, 267 (1993) ("While it is theoretically possible for a statute to create a cause of action that accrues at one time for the purpose of

calculating when the statute of limitations begins to run, but at another time for the purpose of bringing suit, we will not infer such an odd result in the absence of any such indication in the statute"). Here, by only applying the plan language, the Second Circuit's supports "an odd result." *See id.; cf. U.S. Airways, Inc. v. McCutchen*, 133 S. Ct. 1537, 1548 (2013) (if a plan wants to "depart from the well-established common-fund rule, it had to draft its contract to say so"). Instead, the bright line rule informs all parties of the exact deadline for the filing of a lawsuit, while the reasonableness rule does not. ERISA demands such exactitude to fulfill its primary policies. *See* Section 2(b), 29 U.S.C. § 1001(b) (participants must have "ready access to the Federal courts" to remedy a denial of a benefit claim in accordance with Congress' policy as set forth in ERISA).

I. A CAUSE OF ACTION ACCRUING BEFORE THE COMPLETION OF THE MANDATORY INTERNAL CLAIMS REVIEW PROCESS IS AT ODDS WITH THE JUDICIALLY CREATED EXHAUSTION REQUIREMENT.

A. Courts Have Characterized The Exhaustion Requirement As A "Win-Win" For Both Participants And Plans.

ERISA requires that all employee benefit plans must include a claims and appeals procedure which provides adequate notice in writing to any

participant of a denied benefit claim, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and affording a participant with "a reasonable opportunity" "for a full and fair review" of that denied claim. Section 503, 29 U.S.C. § 1133. However, the statute itself does not mandate that participants must exhaust internal claims procedures before proceeding to court. Instead, the mandatory exhaustion requirement was judicially created. *See Amato v. Bernard*, 618 F.2d 559, 566-67 (9th Cir. 1980); *Whitehead v. Okla. Gas & Elec. Co.*, 187 F.3d 1184, 1190 (10th Cir. 1999) (ERISA exhaustion is a judicial, not contractual, doctrine). "Virtually all of the federal circuits have recognized the exhaustion requirement." *Fallick v. Nationwide Mut. Ins. Co.*, 162 F.3d 410, 418, n.4 (6th Cir. 1998) (listing cases).

Courts have explained the many purposes of exhausting internal remedies. A review of the legislative history indicates that the main reason was to provide participants with a simple, low cost, efficient, fair method to protect their benefit rights. *See Richardson v. Cent. States, Se. & Sw. Areas Pension Fund*, 645 F.2d 660, 665 (8th Cir. 1981) ("The statute and the regulations were intended to help claimants process their claims efficiently and fairly; they were not intended to be used by the Fund as a smoke screen to shield itself from legitimate claims"); *Halpin v. W.W. Grainger, Inc.*, 962 F.2d 685, 693 (7th Cir. 1992) (exhaustion of internal process "enables the claimant to prepare adequately for appeal to the federal courts"); *Taylor v. Bakery & Confectionary Union & Indus. Int'l Welfare Fund*,

455 F. Supp. 816, 820 (E.D.N.C. 1978) (employees would incur costs "because, rather than utilize a simple procedure which allows them to deal directly with their employer, they would have to employ an attorney and bear the costs of adversary"); *see generally* Jay Conison, *Suits For Benefits Under ERISA*, 54 U. Pitt. L. Rev. 1, 21-25 (1992) (reviewing ERISA's legislative history of §§ 502 and 503).

Courts have also focused on the benefits that a mandatory exhaustion requirement provides the plan. The benefits to the plan range from enhancing the ability of plan fiduciaries to expertly and efficiently manage their funds by preventing premature judicial intervention in their decision-making processes and permitting the internal plan procedures to work, *Amato v. Bernard*, 618 F.2d 559, 567 (9th Cir. 1980); providing trustees with the time to interpret plan provisions and correct their errors, *Costantino v. TRW, Inc.*, 13 F.3d 969, 975 (6th Cir. 1994); promoting uniform processing and consistent treatment of benefit claims, *id.*; reducing litigation costs, *Amato* 618 F.2d at 567; *Grossmuller v. UAW* 715 F.2d 853, 857 (3d Cir. 1983); and reducing frivolous lawsuits; *Amato*, 618 F.2d at 567. Of particular importance to the courts is that exhaustion of the internal claims procedure helps to assemble a record of the fully considered actions by fiduciaries interpreting their plans and further refines the issues, thus assisting courts when they are called upon to resolve disputed claims. *Amato*, 618 F.2d at 568.

"[T]he end product of a claims review process wherein § 1133 and its regulations have been followed faithfully is a benefits decision that is thoroughly informed by the relevant facts and the terms of the plan and, if benefits are denied, includes an explanation of the denial that is adequate to insure meaningful review of that denial." *Schadler v. Anthem Life Ins. Co.*, 147 F.3d 388 (5th Cir. 1998). It is only after participants have exhausted plans' internal appeals procedure that they can file suit,[5] if they so desire.

B. The Mandatory Exhaustion Requirement Has Been Successful In Reducing The Number Of Lawsuits Filed To Recover Benefits.

There are millions of claims filed with plans every year, with most of them paid and not disputed. *Cf.* U.S. Dep't of Labor, *Private Pension Plan Bulletin Abstract of 2010 Form 5500 Annual Reports*, Emp. Benefits Sec. Admin., 1-3 (Nov. 2012), http://www.dol.gov/ebsa/PDF/2010pensionplanbulletin.pdf (701,000 pension plans with 1.29 billion participants); U.S. Dep't of Labor, *Group Health Plans Report Abstract of 2010 Form 5500 Annual Reports*, Emp. Benefits Sec. Admin., 1-3 (Dec. 2012), http://www.dol.gov/ebsa/pdf/ACA-ARC2013.pdf (48,544 group health plans with 68 million participants). It can be deduced that each year, millions of claims are also appealed under plans'

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[5] In extremely limited circumstances, courts have recognized exceptions to the exhaustion requirement. *See generally* Jeffrey Lewis et al., *Employee Benefits Law* 13-39-41 (3d ed. 2012).

internal claims process. *E.g., Metro. Life Ins. Co. v. Glenn*, 128 S. Ct. 2343, 2350 (2008) (noting that approximately "1.9 million beneficiaries of ERISA plans have health care claims denied each year") (citing Gresenz, C., et al., *A Flood of Litigation? Predicting the Consequences of Changing Legal Remedies Available to ERISA Beneficiaries,* Health Rand Law, 8 (1999), http://www.rand.org/pubs/issue_papers/2006/IP184.pdf (all Internet materials as visited June 9, 2008, and available in Clerk of Court's case file).[6] Yet for all of the claims filed, appealed, and decided under the internal claims procedure of plans, there is only a miniscule fraction of benefit denials funneled into actual litigation in any court. *See, e.g.*, Susan M. Mangiero, *ERISA Fiduciaries Beware: Risk Is More Than a Four-Letter Word*, 19 Prob. & Prop. 65, 65 (2005) ("According to the Admin. Office of the U.S. Cts., new [ERISA] cases [numbered] 9,167 ... in 2000 [and] 11,499 ... in 2004."). Clearly, the judicially created exhaustion requirement has effectively worked to reduce the number of cases that are filed under section 502(a)(1)(B). *See Commc'n Workers of Am. v. AT&T*, 40 F.3d 426, 432 (D.C. Cir. 1994) ("the exhaustion requirement may render subsequent judicial review unnecessary in many ERISA cases because a plan's own remedial procedures will resolve many claims").

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[6] This statistic does not include denials of claims for retirement, disability, life insurance, and other employer sponsored benefits.

II. A BRIGHT LINE IMPLIED CONTRACT TERM COMMENCING ON THE DATE OF A FINAL BENEFIT DENIAL IS THE ONLY IMPLIED TERM CONSISTENT WITH A MEANINGFUL CLAIMS PROCEDURE AND MANDATORY EXHAUSTION.

Because the exhaustion requirement has worked so well, it makes no sense to permit plans to adopt accrual rules which are so at odds with the purposes for requiring mandatory exhaustion.

First, under the plain language of Section 502(a)(1)(B), there can be no civil action until there is reason to recover benefits due under the plan, *i.e.* a denial of a claim. Thus, Section 502(a)(1)(B) should be read as starting the accrual period when the claimant receives notification that the claim is finally denied because there is no injury relating to a benefit denial until the mandated claims procedure is concluded.[7] This reading is the result of the judicially imposed requirement that a plan's internal claims procedure must be exhausted before the cause of action accrues.

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[7] This would be consistent with those circuit courts that have permitted the accrual of a benefit denial to commence when the participant has received a clear and final repudiation of the claim. *See Miller v. Fortis Benefits Ins. Co.*, 475 F.3d 516, 521 (3d Cir. 2007) (citing cases) ("clear repudiation" means a fiduciary repudiates a claim for benefits and that repudiation is clear and made known to the participant).

Second, a bright line term – the cause of action accrues begins after the internal claims process is complete – provides the participant with notice that the time has started to run for the filing of his or her lawsuit. The participant will know when the limitations period expires because it has a fixed beginning date – the date there is a "clear and continuing repudiation" of the claim, which also happens to be the time a claimant is first allowed to bring suit.

Third, a bright line term also avoids potential misuse by plans which may adopt buried pre-exhaustion accrual date periods. We know from past experience that plans will add these provisions to the plan along with short limitations periods, thereby reducing the time for claimants to file a lawsuit to protect their benefits to incredibly short periods. Adding plan provisions in response to Supreme Court decisions has occurred before, *see* Brendan Maher, *Creating A Paternalistic Market For Legal Rules Affecting The Benefit Promise*, 2009 Wis. L. Rev. 657, n.76 (2009) (detailing the rush of plans to incorporate discretionary clauses into their plans after *Firestone*), with well-known misuse by certain plans and providers. *See* John Langbein, *Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials under ERISA*, 101 Nw. U. L. Rev. 1315 (2007). Indeed, the misuse of the discretionary clause approved by this Court in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), was so open and notorious that not only did courts comment on it, *e.g.*, *Radford Trust v. First Unum Life Ins. Co.*, 321 F. Supp. 2d 226, 247 (D.

Mass. 2004), *rev'd in part, appeal dismissed in part*, 491 F.3d 21 (1st Cir. 2007) (Unum's claim processing was a "pattern of erroneous and arbitrary benefits denials, bad faith contract misinterpretations, and other unscrupulous tactics."), but the National Association of Insurance Commissioners enacted a Model Act to ban such clauses, Henry Quillen, *J. Pension Planning & Compliance*, Summer 2006, at 67, which now has been adopted in some form by almost half of the states, ironically making state laws more protective of participants than ERISA on this issue. *See* NBC 10, *I-Team: New law bans discretionary clauses* (Jun 25, 2013), http://www.turnto10.com/story/22685544/i-team. It is not an overstatement to say that plan counsel are lying in wait for the decision in this case. See Amy Covert & Aaron Feuer, *View From Proskauer: The Supreme Court to Opine on Use of Contractual Limitation Periods in ERISA Plans,* Bloomberg Law (2013), http://about.bloomberglaw.com/practitioner-contributions/the-supreme-court-to-opine-on-use-of-contractual-limitation-periods-in-erisa-plans/ ("Pension plans could include provisions requiring that a challenge to benefit calculations must be filed within a reasonable period after a participant receives an annual statement of his or her accrued benefit, or when the participant terminates employment, rather than at the point of retirement"); Patrick Begos, *Statute of Limitations Can Start Running Before Claim Accrues,* ERISA Claim Defense Blog (Sept. 24, 2012), http://www.erisaclaimdefense.com/statute-of-limitations-can-start-run ning-before-claim-accrues/; Aaron A. Reuter, *Limiting ERISA's Limitations Period through the Use of Contractual Accrual Dates*, ERISA

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Thus, it is not a farfetched conclusion that there will be substantial incentives for some plans and providers to delay resolution of benefit claims so that participants will not have the ability to file suit. This could happen in two ways. The decision on the claim could be so delayed that the claimant does not realistically have time to review the claim, obtain a lawyer and file suit. Even worse, the claim could be decided after the accrual period has run, totally depriving claimants of their right to file suit to protect their benefit claims. Alternatively, lawsuits may be filed prematurely because counsel does not have sufficient time to scrutinize the claim and explain the case to the claimant before the statute of limitations has run.

Even if a plan does not intentionally delay benefit claims decisions, the internal review process can take much longer than the potential accrual time frames and even the time frames in the interpretive

regulations. For example, in reviewing disability claims, medical records must be obtained, independent medical examinations may be sought for various assessments and outside evaluators may be used, adding substantial time to the process. *E.g.*, *McCauley v. First Unum Life Ins. Co.*, 551 F.3d 126 (2d Cir. 2008) (awarding the claimant disability benefits thirteen years after his first application).

Claims for disability pensions raise similar issues to long-term disability claims, plus many retirement plans first require a participant to obtain a Social Security disability determination in order to meet the plan's eligibility requirements. Applying for Social Security retirement and going through the Social Security appeals process, if necessary, can take close to three years. Soc. Sec. Admin., *Waiting Period for Social Security Disability* (Feb. 20, 2013), http://ssa-custhelp.ssa.gov/app/answers/detail/a_id/151/related/1/session/L2F2LzEvdGltZS8xMzcxNzMxODM0L3NpZC80R0N2VWN0bA%3D%3D ("The five month waiting period ensures that during the early months of disability, we do not pay benefits to persons who do not have long-term disabilities."); Soc. Sec. Admin., *Length of time to receive approval or denial decision on disability claim* (June 15, 2013), http://ssa-custhelp.ssa.gov/app/answers/detail/a_id/ 159/~/length-of-time-to-receive-approval-or-denial-decision-on-disability-claim ("The length of time it takes to receive a decision on your disability claim is from three to five months."); Soc. Sec. Admin., *Time frames during the hearing process* (Dec. 4, 2012), http://ssa-custhelp.ssa.gov/app/answers/detail/a_id/1160/kw/how%20long%20does%20it%20take%20alj%20to%20dec

ide%20my%20case ("The average amount of time needed to process a hearing request during fiscal year 2010 was 426 days."); Soc. Sec. Admin., *Length of time it takes the Appeals Council to decide my case* (Mar. 31, 2013), http://ssa-custhelp.ssa.gov/app/answers/detail/a_id/1167/kw/how%20long%20does%20it%20take%20to%20appeal%20a%20disability%20denial ("The Appeals Council take about a year to give proper consideration to each case to ensure the agency's final action is correct.").

Even an apparently generic pension claim can result in a prolonged deliberation if there are questions over a participant's work history and crediting of service. Myron D. Rumeld, Russell L. Hirschhorn & Brian Neulander, *ERISA's Statute of Limitations for Benefit Claims: Where To Begin?*, ERISA Litigation Newsletter, 4 (July 2010), http://www.proskauer.com/publications/newsletters/erisa-litigation-newsletter-july-2010/ ("In some contexts, particularly pension claims that are filed when a participant reaches retirement age, the claim itself may present issues that depend on information dating back to the participant's earlier years of active employment.").

Adoption of any implied provision other than a bright line at the clear and final denial of a benefit will undermine and frustrate both the Congressional determination that plans should have meaningful claims procedures and the uniform view of the federal courts that such procedures mandate exhaustion of the internal claims procedures.

III. AN IMPLIED REASONABLENESS TERM IS UNWORKABLE IN ERISA BENEFITS CASES BECAUSE IT IS STANDARDLESS, INCONSISTENT WITH ERISA'S NOTICE REQUIREMENTS, LEADS TO ABSURD RESULTS AND PROVIDES BOTH PLAN ADMINISTRATORS AND CLAIMANTS WITH INCENTIVES WHICH ARE AT ODDS WITH THE MANDATORY EXHAUSTION REQUIREMENT.

A. An Implied Reasonableness Term Is Subjective And Malleable.

Courts imply a reasonableness term into a contract when they have inadequate alternatives. ERISA cases do not present the Court with this dilemma.

An implied reasonableness term employed by courts in some circuits, and urged by Respondent in this case, fails to provide clarity, fair notice, or meaningful guidance to claimants and courts. Under this implied term, whether a plan's contractual accrual period may be enforced depends on whether the claimant had a reasonable time in which to file suit after completing the administrative process. *See, e.g., Salisbury v. Hartford Life & Accident Co.*, 583 F.3d 1245, 1248-49 (10th Cir. 2009); *Abena v. Metro. Life Ins. Co.*, 544 F.3d 880, 884 (7th Cir. 2008); *Burke v. PriceWaterHouseCoopers LLP Long Term Disability Plan*, 572 F.3d 76, 81 (2d Cir. 2009).

But reasonableness is a highly flexible concept, and courts "have no ready means of determining . . . how much 'compressing' of the plaintiff's limitations period was too "severe [ ]." *White v. Sun Life Assur. Co. of Can.*, 488 F.3d 240, 248-9 (4th Cir. 2007). If a reasonableness term is implied, claimants are left guessing whether a suit filed after the expiration of a contractual limitations period will be allowed. For example, in *Rotondi v. Hartford Life & Accident Grp.*, No. 09 Civ. 6287(PGG), 2010 WL 3720830, at *8 (S.D.N.Y. Sept. 22, 2010), the court concluded that a period of five months from final denial of the claim to the running of the plan's limitations period was fair, and granted summary judgment for the defendant on the ground that the suit was untimely. *Id.* In contrast, in *Hinojos v. Prudential Ins. Co. of Am.*, CIV. 10-1193 JH/LAM, 2011 WL 7768621 (D.N.M. Oct. 19, 2011), the contractual limitations period likewise expired five months after the conclusion of the administrative process, and the claimant filed suit thereafter. The court refused to dismiss the case as untimely, finding that it would be "unreasonable to deny Hinojos the benefit of ERISA's protection after he spent the time and effort exhausting his administrative remedies as ERISA requires." *Id.* at *7. This type of inconsistent adjudication is inevitable where the only standard governing court review is "reasonableness."

Moreover, "whether an accrual provision was 'reasonable' with respect to a particular claimant would change each day that the plan did not issue a final decision." *White,* 488 F.3d at 248. The longer the plan administrator takes to render a decision on

which the claimant can file suit, the less reasonable the accrual provision. Although this is arguably a check on the perverse incentives created by anything other than a bright-line rule that benefits claims accrue at final denial, discussed herein, *see supra* at 12-18 and *infra* at 23-25, it highlights that "reasonableness" is really no standard at all.

A reasonableness term is unpredictable in the extreme. For example, cases speak of situations where the plan might delay its decision until close to or after the contractual limitations has expired. *E.g.*, *Baptist Mem'l Hosp.--DeSoto, Inc. v. Crain Auto. Inc.*, 392 Fed. App'x. 288 (5th Cir. 2010). Is 30 days unreasonable when the plan intentionally delayed and reasonable when the plan did not? How much discovery will be required to determine the true motives of the plan administrator? What if the plan asks the claimant for more information and the claimant takes a long time to provide it? The mandatory appeal process is suspended during that time. See 29 C.F.R. § 2560.503-1(f)(4); § 2560.503-1(i)(4); *see also* Preamble to Final Rule of Claims Procedure, 65 Fed. Reg. 70,246, 70250, n.21 (Nov. 21, 2000). If the appeal period pushes right up against the limitations period, will it matter if the request was in good faith? Will it matter if the claimant's delayed response was due to sloth, disability or matters outside her control, such as her treating physician being on a vacation? Or part due to each?

An implied reasonableness term will not only undermine uniform administration of any given plan, it will undermine uniformity among the circuit courts

as similar fact patterns will result in different results.

B. An Implied Reasonableness Term Is Inconsistent With ERISA's Notice Requirements.

A capricious, shifting method of determining a benefit claim's accrual date is in direct tension with the statutory and regulatory framework, which emphasize the importance of notifying plan participants in writing of their rights.

ERISA requires plans to "be established and maintained pursuant to a written instrument." 29 U.S.C. § 1102(a)(1). This Court has described this requirement as a "core functional requirement" ensuring that "every employee may, *on examining the plan documents*, determine exactly what his rights and obligations are under the plan." *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 83 (1995) (internal citations omitted) (emphasis in original). The pertinent Department of Labor regulations require written notification of any adverse benefit determination describing "the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action." 29 C.F.R. § 2560.503-1(g)(iv).

Adopting a reasonableness term is not faithful to the statutory purpose or the regulatory language. The limitations period may be written into the plan, but as noted, whether this period is enforceable is not

written into the plan, nor could it be, since it depends on the amount of time it takes to complete the administrative process. As a result, a participant cannot tell from the plan (or, indeed, from a notice of adverse benefit determination) how long he or she might have to file suit. The Fourth Circuit stressed this concern in *White*, noting:

> A sometimes-enforcing approach to accrual provisions would disregard the written plan requirement and make it impossible for plans to give their participants the notice of subsequent remedies required by law. . . . Contractual accrual periods like Sun Life's would be enforced sometimes, but not at other times, according to a standard neither contained in the plan document nor evident from its terms. Rather than apprising plan participants of their rights, the written plan would often mislead claimants by setting forth a purported time limitation that would, in reality, apply only if it satisfied a reasonableness analysis described nowhere in the plan.

White v. Sun Life Assur. Co. of Can., 488 F.3d 240, 248-9 (4th Cir. 2007); *accord*, *Price v. Provident Life & Accident Ins. Co.*, 2 F.3d 986, 988 (9th Cir. 1993) (statute of limitations is only triggered when participant learns of health benefit denial, regardless of plan language, due to ERISA's notice requirements).

Such an implied term undermines ERISA's policy to protect employee benefit rights by providing participants with "ready access to the Federal courts." *See* Section 2(b), 29 U.S.C. § 1001(b).

C. An Implied Reasonableness Term Can Lead To Absurd Results In Some Cases, Because It Is Divorced From The Purpose Of Limitations Periods And Accrual Provisions.

As is true in this case, many contractual limitations periods in ERISA disability plans accrue at the time "proof of loss" is provided to the plan. It makes no sense to enforce a contractual limitations provision when the claimant provides proof of loss and is found to be disabled under the plan, but benefits are later terminated because the claimant is found to no longer be disabled. This change in determination can take place many years after the initial proof of loss and already well beyond the limitations period. The reasonableness of the contractual accrual provision in such cases, depends on the duration of the disability, as determined by the plan administrator. Not surprisingly, courts have varied in their approach to this problem. *Compare Abena v. Metro. Life Ins. Co.*, 544 F.3d 880 (7th Cir. 2008) (enforcing a "proof of loss" accrual period despite plan administrator's approval of the claim for two years), *with Forrest v. The Paul Revere Life Ins. Co.*, 662 F. Supp. 2d 183 (D. Mass. 2009) (declining to enforce proof of loss accrual term when the plan administrator awarded two years of benefits). But regardless of outcome, this factual scenario

highlights a core problem with an implied reasonableness term: it is unmoored from the purpose of limitations periods and accrual rules.

Limitations periods, contractual or statutory, are meant to ensure that litigants do not sit on their rights, allowing evidence to become stale. *See, e.g.*, *Chase Secs. Corp. v. Donaldson*, 325 U.S. 304, 314 (1945); *Holmberg v. Armbrecht*, 327 U.S. 392, 396 (1946). Accrual rules are constructed around this purpose: a cause of action generally accrues when the affected party has a complete claim and can file suit. *See Bay Area Laundry & Dry Cleaning Pension Trust Fund v. Ferbar Corp. of Cal. Inc.*, 522 U.S. 192, 201 (1997). But under the reasonableness term proposed by Respondent and employed by some courts, a claimant who promptly pursues his administrative remedies and files suit within what would otherwise be considered a "reasonable" time – before any evidence becomes stale, after such remedies are exhausted and his claim is thus ripe for litigation – may still be barred by the plan's limitations period. In other words, the reasonableness of a contractual accrual period does not turn on whether the claimant diligently filed suit after his cause of action was complete. It turns on the simple number of months or years between exhaustion of administrative remedies and the expiration of the plan's limitations period. *See Abena*, 544 F.3d at 884 ("if the appeals process was so protracted that the claimant was *unable* to file suit within the contractual period, the application of this provision would not be reasonable") (emphasis added).

Only the bright-line rule that an ERISA benefits claim accrues when the administrative process is exhausted – and the claim is thus unquestionably ready for litigation – is consistent with the logical purpose behind statutes of limitations.

D. An Implied Reasonableness Term Provides The Wrong Incentives, Giving Plan Administrators An Incentive To Delay Resolution Of Claims And Claimants An Incentive To Rush Through The Administrative Process And File Premature Lawsuits.

Amici supports Petitioner's argument requiring an implied term to be read into the plan language, tolling any limitations period during a time a claimant is unable to bring suit. Respondent urges instead to adopt a case-by-case approach and asks the Court to read an implied exception to the plan language under certain circumstances. However, the utility and fairness of Respondent's approach depend on claimants filing lawsuits: if the administrative process continues until very close to or after the date on which the claimant would have to file suit under the plan's limitations provision, the claimant must either file suit prematurely, before exhausting the claim, or take the risk of pursing a lawsuit that is facially untimely. If a claimant is unaware that the limitations period might not be enforced by a court and thus does not attempt to litigate his claim, or cannot find a lawyer willing to spend hours litigating

the procedural issues of "reasonableness under these particular circumstances" question before even getting to the merits, his claim will simply be extinguished. Plan administrators, especially conflicted plan administrators, *see Metro. Life Ins. Co. v. Glenn*, 128 S. Ct. 2343, 2350 (2008), knowing this, would have every incentive to delay resolution of claims as long as possible in the hopes that claimants will just go away. More sophisticated claimants have every incentive to rush through the administrative process or file suit before the administrative process is totally complete in order to preserve their rights. By using an implied reasonableness term, both outcomes are undesirable: claimants are meant to have a right to judicial review and the administrative process is meant to prevent unnecessary litigation. *See supra*, at 10-11, 12-18; *White v. Sun Life. Assur. Co. of Can.*, 488 F.3d 240, 248-9(4th Cir. 2007) ("Courts would be hard pressed to ascertain whether these [perverse] incentives caused a plan to delay a decision, despite the way in which such manipulation of the internal review process undermines both ERISA's civil remedy and internal appeals as mechanisms of 'full and fair review.').

CONCLUSION

For the foregoing reasons, the judgment below should be reversed, and the case remanded for further proceedings.

Dated: July 2, 2013

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AMICUS CURIAE BRIEF

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JULIE HEIMESHOFF,
Petitioner,

v.

HARTFORD LIFE & ACCIDENT INSURANCE CO., ET AL.,
Respondents.

On Writ of Certiorari
to the United States Court of Appeals
for the Second Circuit

BRIEF FOR THE AMERICAN COUNCIL OF LIFE INSURERS, AMERICA'S HEALTH INSURANCE PLANS, AND THE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA AS AMICI CURIAE SUPPORTING RESPONDENTS

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QUESTION PRESENTED

Whether a court should enforce a contractual limitations provision in an ERISA disability benefits policy requiring that any suit be brought within three years after the date proof of loss is due, where that provision gave the claimant more than a year to file suit after the final administrative denial of her claim.

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BRIEF FOR THE AMERICAN COUNCIL OF LIFE INSURERS, AMERICA'S HEALTH INSURANCE PLANS, AND THE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA AS AMICI CURIAE SUPPORTING RESPONDENTS

INTEREST OF THE *AMICI CURIAE*[1]

The **American Council of Life Insurers** (ACLI) is the largest life insurance trade association in the United States, representing the interests of hundreds of member companies operating here. ACLI's member companies are the leading providers of financial and retirement security products covering individual and group markets, including life, disability income, and long-term care insurance products. Indeed, its members account for approximately more than 90 percent of the life insurance industry's total assets, premiums, and annuity considerations. The life insurance policies issued by ACLI members include employer-sponsored group disability insurance policies and group life policies. The annuities issued include group annuities issued to employer-sponsored retirement plans. The vast majority of the products sold by ACLI members in the group employee benefits market are subject to the requirements of

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[1] The parties' blanket consents to the filing of *amicus curiae* briefs are on file with the Clerk. No counsel for a party authored any part of this brief; no party or party's counsel made a monetary contribution intended to fund the preparation or submission of this brief; and no person other than *amici curiae*, their members, or their counsel made a monetary contribution to the brief's preparation or submission.

the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001 *et seq.*

America's Health Insurance Plans (AHIP) is the national association representing health insurance plans that provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. AHIP's members offer a broad range of products in the insurance marketplace, including health, disability, long-term care, dental, vision, and supplemental coverage. AHIP's membership includes a majority of insurers providing group disability insurance. AHIP seeks to facilitate, preserve, and increase the availability of affordable benefit coverage related to health care and disability.

The **Chamber of Commerce of the United States of America** (Chamber) is the world's largest business federation. It represents 300,000 direct members and indirectly represents the interests of more than three million businesses and professional organizations of every size and from every industry sector and region of the country. Its members include many employers that offer ERISA-governed benefit plans to their employees, as well as insurers who fund and/or administer such plans. The Chamber advocates for the interests of the business community in courts across the nation, in part by filing amicus curiae briefs in cases raising issues of national concern to its members. Many Chamber members provide benefits to employees through employee welfare benefit plans regulated under ERISA, including disability income insurance benefits that contain timing provisions like the plan term at issue

in this case. The Chamber's members place great importance on their ability to enforce the terms of ERISA plans as written, including timing provisions that guard against stale claims and contribute to providing affordable coverage.

The question presented here is whether a claim for benefits due under an ERISA plan must be asserted within the time expressly specified in that ERISA plan, which in this case is three years from the date on which the claimant was required to furnish written "proof of loss." Petitioner contends that the plan's timing rule is unenforceable in any action to recover benefits under Section 502(a)(1)(B) of ERISA, 29 U.S.C. § 1132(a)(1)(B), and that the three-year period may run only from the date of the plan's final adverse benefit determination. The resolution of that question will have significant implications for employee benefit plans and the insurance industry as a whole, and will affect the disposition of numerous cases beyond this one. The timing provision at the heart of the present dispute is by no means unique: it is instead a standard feature of the insurance industry, reflecting longstanding practice, and is also required by the insurance laws of nearly every State.

Because of the extensive involvement of the *amici's* members in the field of disability insurance and especially with respect to ERISA-governed group disability plans, the *amici* are well-equipped to address the purposes that the timing provision serves and the manner in which it coexists in harmony with ERISA's pre-suit exhaustion requirement. Contrary to how Petitioner portrays it—as a trap for the unwary that serves no legitimate purpose—the provision under review

serves the traditional, legitimate purposes of statutes of limitations, consistent with ERISA's statutory scheme.

SUMMARY OF ARGUMENT

This case is governed by a plain and unambiguous term of the ERISA plan in which petitioner participated: she was required to file her action to recover benefits within three years after her proof of loss was due. Petitioner cannot seek to recover "benefits due to [her] under the terms of the plan," 29 U.S.C. § 1132(a)(1)(B), if she did not comply with the plan's valid requirements for seeking benefits. Therefore, she must show that the timing requirement is invalid. But she identifies no provision of federal law that precludes ERISA plans from adopting a timing requirement like the one at issue here.

To the contrary: insurance policies have featured timing requirements tied to proof of loss for decades, since long before ERISA. Relying on a model law promulgated by the National Association of Insurance Commissioners, nearly every State *mandates* the use of timing provisions like this one in certain insurance contracts, generally including group disability insurance contracts. This body of state law has coexisted harmoniously with ERISA from the beginning.

Petitioner suggests that, *merely by creating a federal cause of action* to recover employee benefits, Congress rendered all of those State-mandated insurance provisions unenforceable in the context of employee benefits. But ERISA gives no indication that Congress was imposing some unwritten federal accrual rule. Rather, what is clear from ERISA is

that Congress affirmatively *declined* to specify a statute of limitations for benefits-recovery claims, even as it was setting a federal statute of limitations for other ERISA claims. Congress left procedural matters, such as the timing of suit, to ERISA plans themselves in the first instance.

Those procedures are potentially subject to state insurance regulation, which ERISA saves from express preemption. But petitioner does not claim that state law invalidates the timing provision in respondents' plan. To the contrary, most such timing provisions in ERISA plans are not just consistent with state law but mandated by it.

The flexibility to adopt timing provisions like this one is particularly important to ERISA plans and the insurance companies that insure or administer them. Petitioner's rule would substantially lengthen the time within which a claim for benefits can be litigated in court, and it would sever the link between the date of the insured loss and the date when the insurer can close the books on that loss. Indeed, petitioner would give every claimant a period of several years to sue *after* she finishes exhausting her remedies within the plan. That rule would affect insurance companies' decisions to reserve funds based on threatened but not yet asserted claims, which in turn could make welfare benefits like disability insurance more expensive for employees.

Petitioner's rule cannot even be justified on pragmatic grounds, as a solution to a pressing problem, because it does not respond to any genuine issue. Once the plan denied petitioner's claim for disability benefits, petitioner had no basis for waiting nearly *three years* before filing suit.

Petitioner contends that she should get the extra time for the sake of the hypothetical claimant who might need it. But petitioner cites *no case*—and it appears none exists—in which plan delays caused exhaustion to consume the entire limitations period, or even enough of the period to justify a different rule. Rather, the practical problems are with petitioner's rule, which would unnecessarily and unwisely stretch out the period for filing an ERISA action in *every* case, not just the extreme ones.

ARGUMENT

I. ERISA Contains No Provision That Supersedes Or Prohibits The Plan's Timing Rule

On the date that ERISA was enacted, most disability (and other) insurance contracts contained provisions indistinguishable from the one here: requiring the insured to sue for benefits within a certain number of years after the insured's proof of loss was due. Indeed, most States affirmatively *required* those contracts to include such terms. Congress would not have overlooked such a widespread rule during the decade of study leading up to ERISA. Yet petitioner's submission is that by creating a *federal* cause of action to recover those same benefits, Congress intentionally—but utterly silently—prohibited employee benefit plans from continuing to write that commonplace term into their contracts.

That theory lacks any support in ERISA's text, structure, or purpose. Petitioner and her *amici* point to *no* statutory language that forbids ERISA plans from tying the limitations period to the date proof of loss is due, or that sets a different rule as a matter of

federal law. Rather, they contend that something about the federal nature of the ERISA cause of action for recovery of benefits inherently precludes plan terms like this one. But Congress left many aspects of that cause of action to be defined by plan terms and state law. There is no reason to conclude that Congress quietly mandated a new and different federal rule for *this* aspect of the benefits-recovery cause of action—on which there was such a substantial body of state law at the time of ERISA's enactment.

A. The Timing Provision Has Long Been A Mandatory Feature Of Insurance Contracts

The timing provision of the policy at issue provides that no legal action may be taken against the plan "(1) sooner than 60 days after due proof of loss has been furnished; or (2) after the shortest period allowed by the laws of the state where the policy is delivered. This is 3 years after the time written proof of loss is required to be furnished according to the terms of the policy." Pet. App. 56. That provision is not respondents' innovation, nor is it exceptional. Indeed, nearly all States, as well as the District of Columbia, Puerto Rico, and the U.S. Virgin Islands, require that this or a similar provision be included in health and/or disability insurance policies that are issued or delivered within their borders. *See Wetzel v. Lou Ehlers Cadillac Grp. Long Term Disability Ins. Program*, 222 F.3d 643, 647 & n.5 (9th Cir. 2000) (cataloguing statutes); Resp. Br. 6 & n.2.[2]

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[2] Nearly all States set the limitations period at three years, as in this case, but a few specify a longer period.

These provisions have a long pedigree. Many trace their origins at least to the Uniform Individual Policy Provisions Law Model Bill of 1950, proposed by the National Association of Insurance Commissioners (NAIC). That uniform law required policies to contain the following provision, substantially identical to the one at issue here:

> LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Uniform Individual Policy Provisions Law Model Bill of 1950, § 3(A)(11), *reprinted in* William E. Meyer, *Life and Health Insurance Law* app. A (1971).

The use of such provisions in the insurance industry predates the 1950 Model Bill. This Court in 1947, for example, confronted a substantially similar "standard contractual provision" that was mandated by a South Dakota statute enacted in 1919. *See Order of United Commercial Travelers v. Wolfe*, 331 U.S. 586, 612 & n.23 (1947) (citing § 3(14), c. 229, S.D.L. 1919, at 235). Both that South Dakota statute and the 1950 Model Bill apparently derive from an earlier NAIC uniform law promulgated in 1912. *See* Uniform Standard Provisions Bill of 1912, § 3(1)(14), *reprinted in Proceedings of the National Convention of Insurance Commissioners of the United States* 123 (1912) ("No action at law or in equity shall be

brought to recover on this policy prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of this policy, nor shall such action shall be brought at all unless brought within two years from the expiration of the time within which written proof of loss is required by the policy.").

Unsurprisingly given their long history, timing provisions of the type at issue here are typical in health and disability insurance policies today. Even where they are not mandatory as a matter of state law, many plans have adopted them as a sensible and context-sensitive rule for the administration and handling of claims.

B. Congress Adopted ERISA Against The Backdrop Of Established Practice, Including The Timing Requirement

Congress cannot have been unaware of this history when it formulated, and ultimately passed, ERISA's detailed provisions. This Court "generally presume[s] that Congress is knowledgeable about existing law pertinent to the legislation it enacts," and it will not assume that Congress was ignorant of the legal landscape "[i]n the absence of affirmative evidence in the language or history of the statute." *Goodyear Atomic Corp. v. Miller*, 486 U.S. 174, 184-85 (1988); *accord Director, OWCP v. Perini N. River Assocs.*, 459 U.S. 297, 319-20 (1983) ("We may presume that our elected representatives, like other citizens, know the law . . . ." (citation and internal quotation marks omitted)); 2A Norman J. Singer & J.D. Shambie Singer, *Sutherland Statutes and Statutory Construction* § 45:12, at 115 (7th ed. 2013) ("*Sutherland*") ("[L]egislative language will be

interpreted on the assumption that the legislature was aware of existing statutes . . . ."). That rule applies with particular force to ERISA, "the product of a decade of congressional study of the Nation's private employee benefit system." *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 251 (1993). Even more than usual, Congress was well aware of the contours of the terrain it was crossing in enacting ERISA.

Where ERISA is silent on a key point, therefore, the longstanding practice under state law informs its interpretation. Thus, for instance, this Court concluded that Congress did not intend to disturb state laws mandating that plans offer particular benefits, which had become "commonplace" by the time of ERISA. *See Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 742 (1985). Similarly, the Court presumed that when Congress did not specify a standard of review for benefit determinations (and when a plan also did not provide one in its plan documents), Congress intended to adhere to the state of the law as it was in 1974. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 112-13 (1989). *Accord, e.g., Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 367-68, 372-73 (2002) (reviewing Congress's contemporaneous understanding of the legal status of health maintenance organizations in construing the application of ERISA's insurance savings clause). In short, when Congress knew about a particular state-law practice, its "decision to remain silent concerning [that practice] acknowledged and accepted the practice, rather than prohibiting it." *Mackey v. Lanier Collection Agency & Serv.*, 486 U.S. 825, 837 (1988) (citation and internal quotation marks omitted).

Congress knew that many of the employee welfare benefits it was about to regulate consisted of insurance products, including disability insurance. By 1974, the timing provision had been mandated by uniform state insurance legislation for at least 60 years. Congress no doubt also was aware that such provisions had generally been approved by courts as valid contractual terms. *See* 16 Lee R. Russ et al., *Couch on Insurance* § 235:1, at 235-9 to -10 (3d ed. 2005) ("*Couch*") (collecting State cases); *accord, e.g.*, *Wolfe*, 331 U.S. at 610-11; *Riddlesbarger v. Hartford Ins. Co.*, 74 U.S. (7 Wall.) 386, 390 (1869); *see also Sutherland* § 45:12, at 115-20 (legislatures are presumptively aware of "judicial decisions" as well as legislative enactments).

Given that backdrop, it cannot be "assume[d] that Congress was ignorant of the substantial number of States" that required insurance policies to include provisions like the timing provisions at issue here. *Goodyear Atomic*, 486 U.S. at 185. Instead, the strongest inference to be drawn is that Congress was well aware of the timing provision and its mandatory usage by insurers as a function of state law.

C. Congress Did Nothing To Disapprove The Continued Use Of State-Mandated Timing Provisions In ERISA Plans

Petitioner contends that when Congress adopted ERISA, it silently rendered every one of these State-mandated plan provisions unenforceable. But petitioner never identifies anything in ERISA that abrogates this established type of contractual limitations period. Rather, she contends that ERISA creates a federal cause of action, so her preferred

federal accrual rule must apply. But the fact that ERISA is a federal statute does not end the analysis.

What petitioner disregards—and what separates ERISA from, say, TILA, RESPA, or USERRA—is the essential fact that under ERISA, it is the *plan terms* that govern, as a matter of federal law. That is the rule that the Second Circuit applied. *Burke v. PricewaterhouseCoopers LLP Long Term Disability Plan*, 572 F.3d 76, 79, 81 (2d Cir. 2009); *see* Pet. App. 3 (following *Burke*). Petitioner derides that holding as a mistaken application of "state law" instead of federal law. Pet. Br. 30. But determining timeliness in accordance with the plan documents is not a matter of "state law" any more than awarding "benefits due . . . under the terms of the plan" is. 29 U.S.C. § 1132(a)(1)(B). Rather, following the plan terms is what *federal* law requires, unless Congress says otherwise. And while those plan terms may be *regulated*, or even mandated, by state insurance law to the extent that the plan provides insurance, *see* 29 U.S.C. § 1144(b)(2)(A), that only underscores that Congress largely kept its hands off what the parties could agree to in a benefits contract.

If a plan provision is valid, it governs. Here, petitioner cannot point to anything concrete that Congress said or did to invalidate the timing provision of respondents' plan. The plan language therefore is controlling.

1. Under ERISA, most key aspects of benefits and their administration are set by the terms of the plan

This is a claim for "benefits due . . . under the terms of the plan"; under ERISA, any question of

entitlement to benefits begins with the terms of the plan. ERISA's entire scheme is built on "reliance on the face of written plan documents." *U.S. Airways, Inc. v. McCutchen*, 133 S. Ct. 1537, 1548 (2013) (citation and internal quotation marks omitted). That "written instrument" must "specify[] the basis on which payments are made . . . from the plan." 29 U.S.C. § 1102(a)(1), (b)(4). And plan administrators must act in accordance with those "governing" instruments. *Id.* § 1104(a)(1)(D). It is those documents, not the statute itself, that primarily regulate how a plan participant may qualify for benefits.

In fact, ERISA "contains almost no federal regulation of the terms of benefit plans." *Metro. Life*, 471 U.S. at 732. Instead, Congress drew ERISA's provisions so as to preserve, not abrogate, employers' freedom to define what benefits will be provided and on what terms.[3] Employers thus have a wide range of options and may decide whether to offer particular types of benefits (*e.g.*, disability insurance, or vision coverage) depending on the needs of their employees. That flexibility reflects a conscious decision on Congress's part: it encourages employers to make

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[3] *See, e.g.*, *McCutchen*, 133 S. Ct. 1537, 1548 ("The plan, in short, is at the center of ERISA."); *CIGNA Corp. v. Amara*, 131 S. Ct. 1866, 1876-77 (2011) (Section 502(a)(1)(B) "speaks of '*enforc[ing]*' the 'terms of the plan,' not of *changing* them") (emphasis in original); *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 833 (2003) ("[E]mployers have large leeway to design [ERISA] disability and other welfare plans as they see fit."); *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996) ("Nothing in ERISA requires employers to establish employee benefits plans. Nor does ERISA mandate what kind of benefits employers must provide if they choose to have such a plan.").

the voluntary decision to establish a benefit plan subject to ERISA. *See, e.g.*, *Conkright v. Frommert*, 130 S. Ct. 1640, 1648-49 (2010) ("ERISA represents a careful balancing between ensuring fair and prompt enforcement of rights under a plan and the encouragement of the creation of such plans.") (citations and internal quotation marks omitted).

Flexibility in plan design extends not only to what benefits are due, but also to how the plan will administer those benefits. *See id.* at 1649 (explaining that Congress sought to prevent unnecessary administrative costs or litigation expenses from "unduly discourag[ing] employers from offering [ERISA] plans in the first place") (citation omitted) (second brackets in original). For example, the plan documents may authoritatively answer the procedural questions of how beneficiaries are to be designated and paid. *See Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan*, 555 U.S. 285, 300-01, 303 (2009); *Egelhoff v. Egelhoff*, 532 U.S. 141, 147-48 (2001). Similarly, this Court has explained that even the standard of review that applies in a judicial action challenging the plan administrator's decisions is primarily "a matter of plan design," although to the extent the standard of review is set through insurance contracts, it may be subject to "substantive state regulation." *Rush Prudential*, 536 U.S. at 386.

Congress certainly can provide exceptions to the ordinary rule that "the agreement governs." *McCutchen*, 133 S. Ct. at 1547.[4] But this Court does

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[4] *See, e.g.*, 29 U.S.C. § 1110(a) (declaring certain exculpatory provisions unenforceable).

not presume from silence that such an exception exists.

2. Congress left the timing decisions to the plan documents, consistent with State law

In creating a federal cause of action to recover benefits, Congress did not set any federal rule affecting a plan's ability to regulate the presentation and assertion of claims. Rather, Congress left those matters to the plan and, in certain respects, to state law.

Before ERISA, claims for benefits were litigated in accordance with the plan documents. *Firestone*, 489 U.S. at 112-13. Congress did not dramatically change that rule in ERISA. While Congress provided a federal cause of action and required in general terms that the plan provide some avenue for administrative review, 29 U.S.C. §§ 1132(a)(1)(B), 1133, Congress preserved the concept that the plan documents are central to the claim, and it did not extensively regulate what plan documents may provide.

Instead, ERISA preserved the States' authority to enact "law[s] . . . regulat[ing] insurance," 29 U.S.C. § 1144(b)(2)(A), which can regulate the insurance products offered by the plan.[5] Sometimes that state regulation takes the form of legislation specifying what insurance benefits a plan must offer. *See, e.g.*, *Metro. Life*, 471 U.S. at 741-43. But the States'

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[5] Congress made an exception for plans that do not buy insurance but self-insure. *See* 29 U.S.C. § 1144(b)(2)(B); *see also FMC Corp. v. Holliday*, 498 U.S. 52, 61-65 (1990).

authority is broader than that. This Court has read the savings clause as authorizing *procedural* regulation as well, allowing the States to regulate the timeliness, denial, and administrative review of claims for such benefits. Thus, for instance, this Court upheld California's authority to regulate when an insurer may deny a claim as presented too late. *See Unum Life Ins. Co. of America v. Ward*, 526 U.S. 358, 375-77 (1999). And the Court likewise upheld Illinois's law significantly altering the procedure for administrative review of insurance benefit denials. *See Rush Prudential*, 536 U.S. at 365-75.

Less explicitly but no less clearly, the statute also permits state law to govern the timing of judicial review under ERISA even when that subject is not addressed by plan documents. Congress provided a statute of limitations for some claims under ERISA, *see* 29 U.S.C. § 1113, but not for others. As relevant here, the statute is silent about when a plaintiff must bring a claim like petitioner's for benefits due under the plan. Under the "longstanding" rule at the time of ERISA, state law would therefore presumptively set the limitations period. *See, e.g., N. Star Steel Co. v. Thomas*, 515 U.S. 29, 33-35 (1995); *accord, e.g., United Auto Workers v. Hoosier Cardinal Corp.*, 383 U.S. 696, 704-05 (1966).

None of these aspects of ERISA is consistent with petitioner's theory that Congress intended to impose an inflexible federal timing rule—and thus to preclude the well-established practice of linking the timing of suit to the presentation of proof of loss. To the contrary, Congress's silence on the subject suggests the opposite: as Congress provided neither the rule of decision nor the timing rules, it allowed

plans to regulate those matters by contract, subject to state insurance regulation.

Had Congress deemed the inclusion of timing provisions in ERISA plan documents at all troubling, it had many options at its disposal. It could have expressly prescribed when a suit for benefits due under the plan must be filed, as it did for other types of ERISA claims, or it could have prescribed an accrual rule. But Congress did neither of those things. And in the absence of something *in ERISA* to show that Congress sought to forbid plans from using the same well-established timing rule that they had used for decades, the "general principles" to which petitioner adverts cannot "override the applicable contract." *McCutchen*, 133 S. Ct. at 1551.

II. The Purposes Of The Timing Provision Are Consistent With ERISA's Statutory Scheme

Even if petitioner's appeal to broad policy objectives were relevant in answering a question governed so plainly by the plan documents, the plan's timing provision serves a purpose that is perfectly compatible with ERISA and its objectives. Petitioner's depiction of the provision as a rule that no one would want and that serves only to thwart judicial review (Br. 2-3) completely disregards the provision's actual aims and focuses instead on a wholly unrealistic hypothetical. The timing provision is not a means of impeding judicial review, and in fact *no one* has yet identified *a single person* whose attempt to seek judicial review was stymied by an overly protracted administrative claims process. Instead, basing deadlines on the proof-of-loss date serves important interests in finality and

financial stability that benefit both plans and their participants.

Like all limitations provisions, statutory and contractual alike, the timing provision sets a clear deadline for claimants to assert their right to sue, and it thus protects the plan against stale claims and the difficulties of proof they present. That objective is particularly important for ERISA-governed disability plans and their insurers. By setting a clear expiration date on potential benefits claims, the provision tells the insurer when it need no longer reserve funds against the potential liability that such claims represent. The ability to determine with near certainty when the books may be closed on a claim in turn benefits all stakeholders. First, reserves—including reserves based on stale claims—directly affect a plan or insurer's solvency and the amounts it must charge for premiums. Second, enforcing the accrual provision in both non-ERISA and ERISA-governed policies alike ensures that ERISA does not create a disincentive to offer these forms of insurance to employees as welfare benefits.

These salutary purposes are not at odds with ERISA's remedial scheme. To the contrary, the accrual provision accords with both the timetable on which plan administrators are legally required to process benefits claims and internal appeals and with judicial review after that process has run its course. Federal regulations strictly limit the extent to which plan administrators may delay the processing of claims or internal appeals, and impose serious consequences on administrators who might be tempted to try such gamesmanship. Moreover, the nature of federal court proceedings following the internal claims and appeals process—generally, the

review of an essentially closed paper record, not a full-blown evidentiary proceeding—means that claimants hardly need a period of years to prepare their case before seeking federal judicial review.

Combined, these realities more than allay the speculative concerns petitioner and her *amici* raise about opportunistic plan administrators running out the clock: claimants simply do not need the entire three-year limitations period (or even the majority of that period) to allow them to transition to federal court, and federal regulations assure that they will have ample time to prepare. Thus, while the timing provision was developed before ERISA, it fits hand in glove with ERISA's larger framework, evincing no reason why it should not be enforced along with the other provisions of the plan.

A. The Timing Provision Serves Sound Purposes Benefiting All Stakeholders In ERISA-Governed Disability Policies

All limitations provisions protect courts and defendants "from having to deal with cases in which the search for truth may be seriously impaired by the loss of evidence, whether by death or disappearance of witnesses, fading memories, disappearance of documents, or otherwise." *United States v. Kubrick*, 444 U.S. 111, 117 (1979). Those concerns are particularly powerful in the context of claims for disability benefits under ERISA. A claim for judicial review of a disability denial may be seeking retroactive benefits for a period of many years, during which time a claimant's disability status may have changed. Indeed, for *short-term* disability claims, the claimant may no longer contend that she *is* disabled, but only that she *was*. Both types of

claims may turn on a claimant's past physical condition and activities, which may be difficult or impossible to reconstruct—or to impeach—once years have passed. And while all evidence is supposed to be submitted during the initial claims process, courts conducting judicial review sometimes either consider new evidence themselves or remand for the plan administrator to do so. *See, e.g.*, *Rekstad v. U.S. Bancorp*, 451 F.3d 1114, 1119, 1121 (10th Cir. 2006) (remanding to plan administrator question of entitlement to benefits for period beginning more than ten years before the remand); *Buffonge v. Prudential Ins. Co. of Am.*, 426 F.3d 20, 24-25, 31-32 (1st Cir. 2005) (remanding to plan administrator and ordering it to allow new evidence on a claim that the insured became disabled nearly ten years before). Allowing judicial review to *begin* three years after a final claim denial—and many more years after the claimant contends she became disabled—only exacerbates the difficulty of litigating these years-old facts.

In addition, the timing provision establishes a firm cut-off date before which claims for denials of benefits must be brought, guaranteeing plans and insurers repose and finality as to any claims that are not brought within the specified time. The goals of repose and certainty are likewise typical of limitations provisions in general. *See Kubrick*, 444 U.S. at 117 (statutes of limitations "are statutes of repose"). But they are particularly important in the insurance context.

Perhaps more so than other types of defendants, insurers must be able to ascertain their potential claims exposure with reasonable certainty, so that they may properly estimate an appropriate "reserve,"

or expected loss. *See* 1 *Couch* § 2:29, at 2-125 to -27; *see also Md. Cas. Co. v. United States*, 251 U.S. 342, 350 (1920) (discussing the "special meaning" of the term "reserve" in the law of insurance).[6] Under most States' laws, insurers are required by statute "to maintain a legal reserve to meet liabilities on [their] policies" for the protection of their policyholders. 1 *Couch* § 2:29, at 2-125 to -27 (citing examples).[7] Proper estimation of reserves is fundamental in allowing insurers to "'budget' their finances," which has a direct effect on the balance sheet, in turn affecting the amount insurers must charge in premiums and other fees. *See* 17A *Couch* § 251:29, at 251-48; *see also Olin Corp. v. Ins. Co. of N. Am.*, 966 F.2d 718, 723 (2d Cir. 1992) ("[T]imely notice of occurrence assists insurers in estimating the amount of capital they need in reserve for future claims, and the amounts the must charge in premiums.").

By setting a fixed amount of time running from the date on which the loss occurred, such provisions

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[6] "Insurers use several methods or setting reserves," but all involve attempting to forecast the amount of money the insurer can expect to have to pay to resolve a claim in light of the probability of an adverse outcome. Timothy M. Sukel & Mike F. Pipkin, *Discovery and Admissibility of Loss Reserves*, 34 TORT & INS. L.J. 191, 194 (1998).

[7] Similarly, ERISA-governed plans must properly account for the contingent liabilities that unresolved claims for benefits due under the plan represent, including when appropriate by taking a charge against the plan's assets, as a function of the generally accepted accounting principles that plans must follow. *See* 29 U.S.C. § 1023(a)(3)(A); 29 C.F.R. § 2520.103-2(b)(3); Financial Accounting Standards Board, Accounting Standards Codification 450-20-25-2 (requiring charge against assets to be recognized for a loss contingency if it is probable to occur and if its amount can be reasonably estimated).

allow insurers to know with greater certainty which claims are too late and which may still be asserted. That knowledge allows insurers to close the books on stale claim files and relieves them of the need to reserve against those claims, or at least allows them to do so on a heavily discounted basis. *See, e.g.*, *Brandywine One Hundred Corp. v. Hartford Fire Ins. Co.*, 405 F. Supp. 147, 151 (D. Del. 1975) ("[T]he purpose of a policy limitation on suit is . . . so that files may be closed at a definite date, uncertainty as to the amount of an insurer's liability avoided, and stale claims cut off."); *Herman v. Valley Ins. Co.*, 928 P.2d 985, 990-91 (Or. Ct. App. 1996) ("Suit limitations provisions . . . enable an insurer to fix its present and future liabilities and to close stale claim files."); *see also* 14 *Couch* § 199:84, at 199-140 (suit limitation provisions "enable[] the insurer to fix its present and future liabilities and close stale claim files").

Under petitioner's rule, by contrast, the limitations period would run not from the date of the insured loss, but from the conclusion of administrative review—leaving plans and insurers unable to predict the limitations period until several contingent events have occurred. Absent a concrete limitations period, an insurer "could not accurately forecast its future liabilities, set aside proper reserves, or close even ancient claim files." *Herman*, 928 P.2d at 991. An insurer faced with an uncertain limitations period will therefore require larger reserves—enough to cover claims that would otherwise be deemed stale. *See id.* That in turn may

increase costs to plan participants.[8] Moreover, a special rule that would disallow the timing provision in ERISA-governed policies—even though it is uncontroversial in non-ERISA insurance products—might also discourage insurers from offering such policies in the first place. That outcome would undermine, rather than promote, Congress's goal of encouraging employers to offer employee benefit plans. *See Conkright*, 130 S. Ct. at 1649. Avoiding that counterproductive result, as the timing provision does, benefits employees, employers, and insurers alike.

B. The Timing Provision Does Not Forestall Judicial Review

Petitioner and her *amici* nevertheless argue that the timing provision is at odds with ERISA's remedial scheme because, they claim, it *might* enable plan administrators to procrastinate during the mandatory internal claims and appeals process for the entire limitations period (here, three years), effectively shutting the federal courthouse door to worthy claimants. *E.g.*, Pet. Br. 2-3; AARP Br. 15. But no one has yet sighted that particular yeti. So far as petitioner can demonstrate and research can reveal, in the nearly forty years that ERISA has coexisted with timing rules tied to the date of loss, no claim for benefits due under the plan has *ever* become time-barred because of delays attributable to

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[8] *See, e.g.*, Ellen Wertheimer, *Calling It a Leg Doesn't Make It a Leg: Doctors, Lawyers, and Tort Reform*, 13 ROGER WILLIAMS U. L. REV. 154, 181 (2008) (discussing relationship between increased reserve requirements and insurance premiums in malpractice context).

exhaustion. Nor is such a case likely to occur in the future.

1. Federal law limits the time that exhaustion may consume

Contrary to petitioner's contentions, the internal claims and appeals process is far from "open-ended." Pet. Br. 8. To the contrary, the Labor Department's regulations now strictly limit both the amount of time that a plan's internal claims and appeals process can take as well as the number of levels of internal review a plan can require claimants to undergo. *See* Resp. Br. 40-41; 29 C.F.R. § 2560.503-1(c)(2), (d), (f)(3), (h)(3), (h)(4), (i)(3).

While extensions of some of these deadlines are allowed, those extensions are also limited in both number and availability. For example, while the regulations allow the plan to request additional information from the claimant and toll the period for making its decision while such requests are outstanding, the plan also is required to "specifically explain . . . the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues." *Id.* § 2560.503-1(f)(3), (f)(4). And while claimants are guaranteed at least forty-five days to respond to requests for information, plan administrators will still, as a practical matter, set a deadline by the claimant must respond. *See, e.g.*, *MacLennan v. Provident Life & Accident Ins. Co.*, 676 F. Supp. 2d 57, 60 (D. Conn. 2009) (noting that plaintiff was required by the plan to submit additional information or to request an extension of time to do so, by a date certain). Similarly, while the plan administrator may extend the deadline for its initial benefits determination by

a total of up to 60 days, but only if "necessary due to matters beyond the control of the plan." 29 C.F.R. § 2560.503-1(f)(3). The Department interprets that proviso not to include, for example, "delays caused by cyclical or seasonal fluctuations in claims volume," because they are not "matters beyond the control of the plan." 65 Fed. Reg. 70,246, 70,250 (Nov. 21, 2000).

A plan disregards those time limits at its peril. If a plan fails to meet the regulatory deadlines, the participant can go straight to court—and potentially have an argument to defeat the plan's claim to interpretive discretion and the deferential standard of review. *See* Resp. Br. 41 & n.18; 29 C.F.R. § 2560.503-1(*l*). The same consequences follow when plans structure or administer their internal process "in a way[] that unduly inhibits or hampers the initiation or processing of claims for benefits." *Id.* § 2560.503-1(b)(3), (*l*).

2. Following exhaustion, a plaintiff does not need three years to file suit

It is true that *some* of the three-year limitations period will overlap with the time spent exhausting plan remedies. But that overlap is not problematic on its face; as respondents demonstrate (Br. 34), three years from the proof-of-loss date actually gave petitioner a *longer* time than she might have been allowed under her preferred rule. Petitioner cannot show that the timing provision conflicts with ERISA without showing that exhaustion will consume *so much* of the three-year period as to impede meaningful judicial review.

A benefits-due-under-the-plan claim under ERISA requires far less preparation than do more

garden-variety lawsuits. With most claims, the plaintiff must undertake some pre-suit investigation to ensure both that she can plead "sufficient factual matter . . . to 'state a claim for relief that is plausible on its face,'" *Ashcroft v. Iqbal*, 556 U.S. 662, 697 (2009) (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007)), and also that she satisfies Fed. R. Civ. P. 11(b)'s duty of reasonable inquiry. It is in part for that reason that statutes of limitations typically allow the plaintiff a period of years to bring suit: so that she has sufficient time to undertake such investigation. *See Kubrick*, 444 U.S. at 122-24; *see also Gabelli v. SEC*, 133 S. Ct. 1216, 1222 (2013) ("Most of us do not live in a state of constant investigation," and "absent any reason to think we have been injured, we do not typically spend our days looking for evidence").

By contrast, a plaintiff like petitioner cannot credibly claim that she needed three years from the end of internal claims review to investigate her federal claim for benefits. Much of the development of a claim like petitioner's takes place *during* the internal claims review and appeal process. The claimant has the right to present a substantial record to the plan administrator in support of her claim, including documentary and expert evidence, and she also may (as is not uncommon) be represented by counsel or some other authorized representative. *See* 29 C.F.R. § 2560.503-1(b), (d), (h)(2)(ii)-(iv), (h)(3)(i)-(v), (h)(4); *see also, e.g.*, *White v. Sun Life Assurance Co. of Can.*, 488 F.3d 240, 256 (4th Cir. 2007) (Wilkins, C.J., dissenting) (noting claimant was represented by counsel during internal appeals process); *Doe v. Blue Cross & Blue Shield*

United of Wis., 112 F.3d 869, 875 (7th Cir. 1997) (same); Pet. App. 8 (same).

Once the claimant has exhausted the plan's internal claims process, there generally is little if any further factual investigation to be done for purposes of initiating the judicial proceeding, as the district court performs what is usually akin to judicial review of final administrative action on a paper record. *See Doe*, 112 F.3d at 875. Indeed, the federal court's review usually is limited to the record developed during the plan's claims and appeals process, and claimants are often *prohibited* from submitting additional evidence to support their claims. *See, e.g.*, *Muller v. First Unum Life Ins. Co.*, 341 F.3d 119, 125 (2d Cir. 2003) (while district court has discretion to consider non-record evidence, "the presumption is that judicial review is limited to the record in front of the claims administrator" (citation and internal quotation marks omitted); *Kearney v. Standard Ins. Co.*, 175 F.3d 1084, 1094 (9th Cir. 1999) (same); *Perry v. Simplicity Eng'g*, 900 F.2d 963, 966 (6th Cir. 1990) (new evidence may not be considered by district courts even on *de novo* review).

In similar proceedings seeking judicial review of another tribunal's decision on a closed paper record, the time to seek review is ordinarily measured not in years but in months (and sometimes only in days). *See Doe*, 112 F.3d at 875; Fed. R App. P. 4(a)(1). For example, this Court has recognized that, depending on the nature of the claim and the defendants, 90 or 180 days is sufficient to allow a worker to seek judicial review of an arbitration decision under the Labor Management Relations Act, a statutory scheme which (like ERISA) generally requires pre-suit exhaustion. *See, e.g.*, *DelCostello v. Int'l Bhd. of*

Teamsters, 462 U.S. 151, 163-64, 169-72 (1983); *United Parcel Service, Inc. v. Mitchell*, 451 U.S. 56, 62-64 (1981). Congress has made similar judgments when setting other periods of time to seek limited federal judicial review of an agency's or arbitrator's decision. *See, e.g.*, 9 U.S.C. § 12 (90 days allowed for actions seeking to vacate or correct arbitration awards); 42 U.S.C. § 2000e-5(f)(1) (Title VII plaintiffs have 90 days to file suit after administrative review of discrimination charges ends).

Petitioner had more than a year to seek federal judicial review of the denial of her claim. Pet. App. 7-9. But even if some claimants have less time—a period of months—that result is hardly so troubling as to override an otherwise-applicable plan term. To the contrary: because claimants are assured a full and fair opportunity to present their case to the plan administrator, and because they also will generally be barred in federal court from relying on additional new evidence, affording them *three years* to file suit would be far more troubling from the standpoint of repose, *see supra* pp. 19-23. It does not take three years to draft a pleading that may be styled as a complaint, but is in essence a detailed notice of appeal, seeking on-the-record review that is "classically appellate in character." *Cf. City of Chicago v. Int'l Coll. of Surgeons*, 522 U.S. 156, 165 (1997) (Ginsburg, J., dissenting).

3. Purely hypothetical exhaustion delays are not a basis for disregarding an ERISA plan's timing provision

Ultimately, petitioner cannot contend that *she* lacked adequate time to file suit. She therefore contends that her rule is necessary to ensure that

everyone will have adequate time to file suit. But in light of the claims regulations and the modest amount of time necessary to assemble an ERISA claim once exhaustion is complete, she fails to show that timing provisions based on the date of loss pose any genuine danger.

None of the cases on which petitioner principally relies (Pet. 19-27) presents the problem she fears. For example, in the sole appellate decision in which this concern motivated the court to reject a timing provision based on the date of loss, the claimant had ample time remaining on the clock—more than 28 months—once exhaustion was finished. *See White*, 488 F.3d at 256 (Wilkins, C.J., dissenting).

Indeed, the limited number of reported decisions on this issue strongly suggests that there is no real danger of litigants' becoming time-barred during the exhaustion process. The last five years of federal district court cases contain only 48 decisions that address the timeliness of the plaintiff's claim under the applicable limitations period.[9] Of those, 20 do not discuss how long it took for the plaintiff to exhaust remedies because it was unimportant to the court's analysis. Of the remaining 28, exhaustion took on average about 16 months. The median time to exhaust was 15 months.[10]

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[9] A Westlaw search in the DCT database for "ERISA & disability & limitation & 'proof of loss,'" narrowed to include one of the terms "time-barred," untimely, late, "statute of limitation," "limitations period," or "contractual limitations," produces 105 results during that five-year period. Of these, only 48 actually involve a relevant statute of limitations issue.

[10] In none of these cases did exhaustion take more than three years. In only one outlier case, involving extensive delay by the

Without evidence, petitioner's *amicus* United Policyholders (UP) turns to hypotheticals, but even the nightmare scenario it posits does not prove its point—much less justify its legal conclusion. UP postulates a hypothetical claimant whose plan took approximately 21 months to deny her initial benefits claim and first-level appeal as a result of various extensions and exclusions assumed to be permissible under the regulations, noting that under many plans, another level of appeal would be required to exhaust remedies. UP Br. 5-9. UP then supposes—with no basis in the regulations or in evidence—that a second-level appeal might take "an additional year." UP Br. 9. But *even under those extreme and hypothetical facts*, the claimant would still have fully three months (of the 36-month contractual limitations period) left to file in federal court.

Ultimately, the most that UP can suggest is that in a case in which every deadline is stretched to the maximum, exhaustion might consume "nearly three years," but still leave the claimant with months to seek federal judicial review. As shown above, in this context that period of months is adequate. And even if it were not, concerns about the adequacy of the time remaining in such an extraordinary case would not be a reason to give *every* claimant in *every* case the option of waiting several years following

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claimant, did exhaustion come within a month of that length of time. The claimant (represented by counsel) took almost ten months to file his first-level appeal and more than a year to file his second-level appeal; the plan considered his claim for less than 14 months, all told, but the claimant's delays caused exhaustion to take approximately 35 months total. *See Gassiott v. Prudential Ins. Co.*, No. 08 Civ. 7358, 2009 WL 3188428, at *1-2 (S.D.N.Y Oct. 6, 2009).

exhaustion before filing suit. *See Doe*, 112 F.3d at 875.

* * * * *

In the context of accrual and tolling principles, this Court "should not craft rules for the needle rather than the haystack." *Wallace v. Kato*, 549 U.S. 384 (2007) (Stevens, J., concurring in the judgment). Petitioner cannot show that this haystack has ever contained a needle (or will ever contain one). The hypothetical scenario in which plan administrators cause claimants to become time-barred is precisely that—a hypothetical. A merely imaginary problem is no reason to overturn a settled insurance principle, particularly without any basis in the statute's text, structure, or history.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted.

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August 27, 2013

AMICUS CURIAE BRIEF

No. 12-729

In the Supreme Court of the United States

JULIE HEIMESHOFF,

Petitioner,

v.

HARTFORD LIFE & ACCIDENT INSURANCE CO. AND WAL-MART STORES, INC.,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

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INTEREST OF *AMICUS CURIAE*[1]

DRI The Voice of the Defense Bar ("DRI") is an international organization of more than 22,000 attorneys engaged in the defense of civil litigation. DRI is committed to enhancing the skills, effectiveness, and professionalism of defense attorneys. Consistent with this commitment, DRI seeks to address issues germane to defense attorneys, to promote the role of the defense attorney, and to improve the civil justice system. DRI has long supported efforts to make the civil justice system more fair and efficient.

To promote these objectives, DRI participates as amicus curiae in cases, such as this one, that raise issues of import to its membership, to their clientele and to the judicial system. The correct application of statutes of limitations is critical to the orderly administration of justice in civil litigation. Based on the extensive practical experience of its members and their clients, DRI is uniquely suited to explain why this Court should affirm the Second Circuit's decision in this case. The Second Circuit decision is consistent with the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. §1001, et. seq. ("ERISA"), with applicable Department of

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[1] Letters of consent have been filed with the Clerk. Pursuant to Supreme Court Rule 37.6, *amicus curiae* states that no counsel for a party has written this brief in whole or in part, and that no person or entity, other than the *amicus curiae*, its members or its counsel, has made a monetary contribution to the preparation or submission of this brief.

Labor ("DOL") regulations and with this Court's holdings.

INTRODUCTION AND SUMMARY OF ARGUMENT

ERISA does not establish a limitations period for filing actions under Section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), to recover benefits payable by a plan ("Claims for Benefits").[2] For years, the operative rule has been that the language of the Plan determines the time within which Claims for Benefits may be filed in court. For an equally long time, courts faced with Plans that are silent on the issue generally have applied the limitations period specified in the most analogous limitations statute of the state in which the case is filed. *See Burke v. PriceWaterhouseCoopers LLP Long Term Disability Plan*, 572 F.3d 76, 78 (2d Cir. 2009).

Plan documents commonly contain a Claims for Benefits limitations period in order to provide certainty and promote consistency. Otherwise, plans with participants or beneficiaries in multiple states could be required to apply different limitations periods under the same plan.

In harmony with the dual objectives of certainty and consistency, Plan terms often specify the date on which the limitations period begins to run. Typically, such provisions require the limitations period to run from a fixed and determinable date.

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[2] The sole limitations period recited in ERISA is Section 413 which prescribes a limitations period for claims of breach of fiduciary duty and does not apply to this case. 29 U.S.C. §1113.

Settled principles support the Second Circuit's judgment in this case. First, the clear terms of a plan must be upheld. *U.S. Airways, Inc. v. McCutchen*, 133 S. Ct. 1537 (2013). Second, plan sponsors have substantial leeway in designing plans as they see fit. *See generally Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 833 (2003). Moreover, and more specifically, reasonable contractual limitations periods are enforceable in accordance with their terms. *See Order of United Commercial Travelers v. Wolfe*, 331 U.S. 586 (1947). For precisely these reasons, Plan provisions establishing the starting date for a contractual limitations period should be upheld even when the period begins prior to the conclusion of the administrative process; doing so is consistent with the principle that courts should not re-write unambiguous plan terms.[3]

In seeking a different result, petitioner urges the Court to disregard these well established principles. There is no merit to petitioner's contention that it is *per se* contrary to ERISA for a Plan to prescribe a

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[3] *See, e.g., Burke*, 572 F.3d at 79 (enforcing a contractual limitations period beginning three years after "proof of loss" was required); *Rice v. Jefferson Pilot Fin. Ins. Co.*, 578 F.3d 450, 456 (6th Cir. 2009) (same); *Harris Methodist Fort Worth v. Sales Support Servs, Inc. Emp.e Health Care Plan*, 426 F.3d 330, 337-38 (5th Cir. 2005) (same); *Doe v. Blue Cross & Blue Shield United of Wis.*, 112 F.3d 869, 875 (7th Cir. 1997) (enforcing a contractual limitations period that ran from the date of the services for which the benefits were sought); *Blaske v. UNUM Life Ins. Co. of Am.*, 131 F.3d 763, 764 (8th Cir. 1997) (enforcing a limitations period in the plan that ran three years after written "proof of loss" was required).

reasonable limitations period that begins at any time other than the date when a final denial of a claim is issued. Had Congress intended the result petitioner desires, the statute could have been written to say so expressly. It was not.

In contrast to respondents' sound arguments drawn from the text of the statute and governing regulations, the language of the Plan, and the clear directives of this Court's holdings, petitioner conjures up a series of hypotheticals that do not reflect real-world experience. Sorely lacking from the presentations of petitioner and her supporting *amici* are examples of actual claimants who faced the parade of horribles that form the foundation for petitioner's effort to have this Court re-write the contractual language of the Plan. But, the relevant terms of the Plan at issue in this case are typical and have been commonplace for years. Experience over that span of years teaches that the hypotheticals petitioner offers are unlikely ever to arise. Indeed, under the standard petitioner proposes, it is just as easy to offer far more likely counter-hypotheticals in which claimants would have *less time* to file suit than the three years from proof of claim that the Plan in this case provided. In any event, in the improbable circumstance that a future claimant would face the imagined dilemma of having a limitations period expire prior to a final adverse decision on her benefits claim, the courts' traditional equitable powers are fully capable of achieving a proper disposition. In short, there is no justification for departing from this Court's established bright-line test that reasonable Plan language controls.

The judgment of the Second Circuit should be affirmed.

ARGUMENT

THE CLEAR, UNAMBIGUOUS TERMS OF THE PLAN SHOULD NOT BE DISREGARDED OR RE-WRITTEN BY THE COURTS.

There is no dispute in this case that the clear and unambiguous language in this long term disability plan requires the Claims for Benefits limitations period to run from the date "proof of loss" is requested. And, as the court of appeals observed, the plain terms of the Plan provided ample notice and more than adequate time for petitioner to file suit after the administrative process was exhausted. Pet. App. 3-4; *see also, Burke*, 572 F.3d at 81.

Nor is there any dispute that similar language has been commonplace in benefits plans for many years. Despite that long history, petitioner urges this Court to depart from the Plan's express language based on the conjecture that some anomalies could result in the future. Drawing on the experience of its members and their clients in administering benefits plans, and in litigating adverse benefits decisions, DRI will focus in this amicus brief on explaining why petitioner's contentions offer an unrealistic view of the actual world in which benefits plans exist. There is no merit to the arguments of petitioner and her supporting *amici* that:

- a plan's internal claims procedures could potentially be tolled indefinitely, causing the plan's claims procedure to be open-ended, as well as

potentially causing the expiration of the limitations period prior to the exhaustion of the plan's administrative remedies. Pet. Br. 7-8.

- starting the limitations clock prior to completing the plan's internal resolution process discourages good-faith pursuit and administration of the internal claims process, encourages premature resort to federal court and promotes an increase in litigation. Pet. Br. 3, 8.

- fidelity to the contractual limitations period would be more awkward, inefficient and unpredictable than petitioner's preferred requirement (not written in the statute, the regulations, or the Plan) that a limitations period cannot begin until all internal Plan decisionmaking has concluded. Pet. Br. 3.

Petitioner's speculative arguments are not supported by law or empirical data, and should not upend the well-settled principle that the clear and unambiguous terms of a plan must be enforced as written.

A. DOL Claims Procedure Regulations Do Not Allow the Plan Administrator to Delay the Internal Claims Process Indefinitely..

ERISA Section 503 requires that the claims procedure of an employee benefit plan must provide adequate notice in writing to a participant or beneficiary whose claim for benefits has been denied. The statute also requires that the claims procedure must afford a reasonable opportunity for a full and

fair review of the decision denying the claim. 29 U.S.C. § 1133(2).

In implementing that statutory imperative, DOL's claims procedure regulations meticulously set forth the process and timetable for processing benefits claims. 29 C.F.R. § 2560.503-1. If a plan fails to establish or follow claims procedures consistent with the requirements of this regulation, the claimant will be deemed to have exhausted administrative remedies under the plan and shall be entitled to pursue legal action in connection with the claim at issue. 29 C.F.R. § 2560.503-1(l). That, alone, should suffice to refute petitioner's hypothetical concern that administrative limbo could consume the entire limitations period that a plan specifies.

Moreover, DOL's claims procedure regulations provide that the initial claims determination for disability benefits is limited to a 45-day term (subject to two 30-day extensions by the plan administrator which, if utilized, would still limit the maximum time for the plan administrator to determine an initial claim for disability benefits to 105 days). *See* 29 C.F.R. § 2560.503-1(f)(3). The period for considering the final determination on appeal is also 45 days (subject to a possible 45-day extension by the plan administrator). At both the initial stage and on appeal, the limited extensions are available only if the plan administrator determines they are necessary for reasons beyond the control of the plan, such as the failure of the claimant to provide necessary information. If a claim is initially denied because the claimant did not

provide essential information, the time is tolled for specified periods following notice to the claimant that additional information is needed. 29 C.F.R. § 2560.503-1.

The DOL's claims procedure regulations are designed to accelerate the resolution of claims. Strict terms apply to the processing of claims and the plan administrator can enlarge the time to resolve a claim only when the reasons for the extension are beyond the control of the plan. The tolling of the limitations period during the administrative claims process can, therefore, occur only as a consequence of the actions, or inactions, of the claimant. There is, accordingly, no basis for petitioner's suggestion that a plan's claims procedures can be tolled indefinitely when the plan requests more information from the claimant. Pet. Br. 8 ("open-ended"). In the fanciful hypothetical petitioner posits, the claimant – not the Plan – is the only party in a position to cause the delay; the delay is solely the result of the claimant not providing the information requested by the plan to process the claim in a timely fashion. Thus, petitioner's concern about a totally conjectural situation is contrafactual: existing regulations do not allow a plan or plan administrator to trigger an "open-ended" claims process.

Furthermore, the regulations provide that when an administrator fails to follow the plan's claims procedure, the claimant shall be deemed to have exhausted administrative remedies and the claimant can go straight to court to file her Claim for Benefits. Similarly, courts have allowed exceptions to the

exhaustion requirement when the claimant demonstrates that exhaustion would be futile or when the claimant has been denied meaningful access to the claims process. One example is when the plan's exhaustion requirements are ambiguous. *See Watts v. BellSouth Telecomms., Inc.*, 316 F.3d 1203 (11th Cir. 2003). *See also Wilczynski v Lumbermens Mut. Cas. Co.*, 93 F.3d 397 (7th Cir. 1996) (exhaustion of administrative process not required when the health plan denied a claim following the claimant suing the employer on an unrelated matter and claimant sufficiently showed that her employer's hostility arising from her suit made further review futile); *Fallick v Nationwide Mut. Ins. Co.*, 162 F.3d 410 (6th Cir. 1998) (exhaustion not required when a plan's insurer repeatedly resisted efforts by participants and regulators to conform its method for determining "usual and customary" expenses to the written terms of the plan).

In light of the safeguards against delay and administrative abuse already provided in existing regulations, as well as case law providing alternate avenues to court for claimants when the plan's internal claims procedures fail, there is no basis for the wholesale judicial revision of plan terms that petitioner seeks. Nor does the actual experience of these plans over many years offer any justification for the result that petitioner and her supporting *amici* ask this Court to impose.

B. Starting the Limitations Clock Prior to Completing the Plan's Internal Resolution Process Does Not Discourage Good-Faith Administration of the Internal Claims Process or Encourage Premature Resort to Federal Court Or Excessive Litigation.

Nor is there any empirical basis – or examples drawn from actual judicial decisions – for petitioner's assertion that allowing the limitations period to run from the date "proof of loss" is requested somehow impinges on the plan administrator's good faith in processing claims. Pet. Br. 3, 8.

ERISA does not require employers to offer employee benefit plans to employees. *See, e.g., Curtiss-Wright v. Schoonejongen,* 514 U.S. 73, 78 (1995) ("Employers or other plan sponsors are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans"). It is counterintuitive, and certainly without any factual foundation, to suggest that an employer who voluntarily chooses to provide a benefit would then incorporate a provision specifically designed to prevent participants from obtaining the promised benefit. Indeed, the record in this case indicates that – far from being a trap motivated by anti-claimant bias – the "proof of loss" limitations period was expressly endorsed by state law, and for certain types of plans was explicitly made a requirement of state law. Conn. Gen. Stat. § 38a-483(a)(7). Nothing suggests that this limitation period is an obscure scheme to deprive participants of their benefits or

that plan administrators will not process claims in good faith because of the inclusion of this plan provision.

Similarly, there is no empirical support for petitioner's contention that plan participants would be discouraged from seeking benefits or challenging adverse benefits decisions when the plan provisions allow the limitations period to start running prior to the exhaustion of the internal administrative process. Indeed, as petitioner acknowledges, the vast majority of benefits claims are granted by plan administrators; only a small fraction result in litigation. Pet. Br. 9. This statistic necessarily includes claims that are processed by plans containing the "proof of loss" limitations language that is so commonplace and that, in fact, is required by state law in some jurisdictions. *See, e.g., Burke,* 572 F.3d at 78 n.1 (observing that state insurance law mandated a period of at least "two years following the time such proof of loss is required by the policy"). Federal courts have upheld this language for more than a decade. *See* note 3, *supra.* Despite the extensive experience of many plans, over many years, in many states, the grim outcomes that petitioner forecasts have simply not materialized.

For much the same reason, there is no warrant for the government's speculation that allowing the contractual limitations period to run from a date prior to the final denial of the claim "would encourage participants to attempt to expedite internal review by cutting short interaction with the plan and proceeding in a more truncated and adversarial way." U.S. Br. 7. Plans in which the

limitations period runs from the date "proof of loss" is required are nothing new, novel or rare. The absence of real-life examples of the consequences that the government's brief predicts should be a powerful disincentive against changing the law – and changing the express terms of the policy documents – as petitioner requests.

Finally, it is significant that judicial review of a plan's denial of benefits is generally not de novo, but applies the abuse of discretion standard and, therefore, is based on the file that was before the plan administrator. *See generally*, *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 110-115 (1989). Consequently, any reduction in the limitations period would not be unduly burdensome to the claimant since an ERISA Claims for Benefits case is more akin to review of an administrative record than it is to full-scale, full-discovery litigation requiring extensive preparation by the parties.

Lacking any basis for contending that "proof of loss" timing provisions have caused, or are likely to cause, a widespread problem of incorrectly denied benefits, petitioner also lacks a compelling argument that courts are ill-equipped to deal with whatever rare instance may arise. For decades, many federal courts have upheld the "proof of loss" limitations provisions challenged in this case and have successfully employed traditional principles of equitable tolling. *See, e.g.*, note 3, *supra*. This Court's holdings provide strong support for that result. *E.g.*, *Wolfe*, 331 U.S. at 608.

C. The Rule Proposed by Petitioner Would Adversely Affect Other Benefit Plans and Programs.

A requirement that the limitations period must run from the date on which the plan formally denies the claim could actually shorten the time within which a disappointed claimant could seek judicial review. If a specified post-denial period is required, then plans could certainly cut the period from three years to one year, or even shorter. In many comparable contexts, periods as short as thirty to sixty days for review of adverse decisions are the norm. *E.g.*, Fed. R. App. P. 4(a)(1)(A)&(B); Administrative Orders Review Act, 28 U.S.C. § 2344. Surely the relevant period in this case could not be deemed unreasonable, where — even under the shortest measure — petitioner had more than a year from the denial of her claim before the contractual limitations period expired. *See* Resp. Br. 11 n. 7.

A further reason to reject petitioner's insistence on a specified post-denial period is to avoid the disruptive impact on other forms of benefits plans. In disability plans, such as the one inbvolved in this case, the filing of a claim for benefits generally occurs close in time to the events that trigger the claim and the claims process moves quickly. But that is not necessarily the case for other types of claims and other types of benefits plans that could be impacted by the decision in this case.

Under the latitude conferred by ERISA, plan sponsors are entitled to draft benefits plans that provide a reasonable measure of finality to protect against stale claims challenging administrative

decisions made and communicated to the claimant many years earlier. Consider the example of an individual who has been properly notified that he is not eligible to participate in a plan because of his employment classificiation; or not eligible for a particular level of benefits (regardless of the type of benefit offered by the plan). If the plan documents specify that any challenge to that determination must be made within a fixed period from the date of notification, then the finality afforded by that provision should not be vulnerable to a lawsuit many years later – when the underlying documents and decisionmakers are no longer available – by an individual who applies for and is denied benefits for which he was informed long ago that he was not eligible. In the rare event that the earlier eligibility determination was arguably incorrect, there is nothing unreasonable in a requirement that the statute of limitations run from the earlier date. A different rule would enable an individual to file a series of claims challenging the same eligibility decision over a lengthy period, a result flatly contrary to the reasonable language of the plan and also contrary to principles of finality on which limitations periods are based.[4]

Even if it were restricted to long-term disability benefits plans, there is no basis in law or in

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[4] *See* Amy Covert & Aaron Feuer, *The Supreme Court to Opine on Use of Contractual Limitation Periods in ERISA Plans*, Bloomberg Law (2013), *available at* http://about.bloomberglaw.com/practitioner-contributions/the-supreme-court-to-opine-on-use-of-contractual-limitation-periods-in-erisa-plans/.

experience for the strict, inflexible rule petitioner proposes. Given the potential deleterious impact that rule would have in a broad array of other benefits contexts, there is even less to commend petitioner's view and even more reason to reject it.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted.

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AMICUS CURIAE BRIEF

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In The
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JULIE HEIMESHOFF,

Petitioner,

v.

HARTFORD LIFE & ACCIDENT INSURANCE CO. AND WAL-MART STORES, INC.,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Second Circuit

BRIEF OF UNITED POLICYHOLDERS, AS *AMICUS CURIAE*, IN SUPPORT OF PETITIONER

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BRIEF OF *AMICUS CURIAE* UNITED POLICYHOLDERS

INTEREST OF *AMICUS CURIAE*[1]

United Policyholders ("UP") is a non-profit 501(c)(3) organization founded in 1991 that serves as a voice and an information resource for insurance consumers in all 50 states. As part of its mission, UP is concerned about the implementation and application of laws and rules under the Employee Retirement Income and Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*, because a substantial percentage of the insurance market is governed by ERISA.

UP's work is divided into three program areas: *Roadmap to Recovery* (claim assistance), *Roadmap to Preparedness* (promoting insurance/financial literacy) and *Advocacy and Action* (advancing the interests of insurance consumers in courts of law, before regulators and legislators, and in the media). Donations, foundation grants and volunteer labor support the organization's work. UP does not accept funding from insurance companies.

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[1] Pursuant to Supreme Court Rule 37.6, *amici curiae* state that no person or entity other than the *amici curiae*, and their undersigned counsel made a monetary contribution to the preparation or submission of this brief. No attorney for any party authored this brief in whole or in part. The parties' letters consenting to the filing of this brief have been filed with the Clerk's office in accordance with Supreme Court Rule 37.3(a).

Advancing the interests of policyholders through participation as *amicus curiae* in insurance-related cases throughout the country is an important part of UP's work. UP's reputation as a reliable friend of the court was enhanced when its *amicus curiae* brief was cited in this Court's opinion in *Humana v. Forsyth*, 525 U.S. 299 (1999), and its arguments were adopted by the Texas Supreme Court in *Excess Underwriters at Lloyd's, London, et al. v. Frank's Casing Crew & Rental Tools Inc.*, 2008 Tex. LEXIS 92, 51 Tex. Sup. J. (Tex. Feb. 1, 2008), as well as by the California Supreme Court in *Vandenberg v. Superior Court*, 88 Cal. Rptr.2d 366 (Cal. 1999) and numerous other proceedings including *TRB Investments, Inc. v. Fireman's Fund Ins. Co.*, 145 P.3d 472 (Cal. 2006). Other ERISA cases in which UP has been granted leave by the Supreme Court to participate as *amicus curiae* include: *US Airways v. McCutchen*, 133 S. Ct. 1537 (2013); *Hardt v. Reliance Standard Life Insurance Co.*, 130 S. Ct. 2149 (2010); *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008); *Aetna Health, Inc. v. Davila*, 542 U.S. 200 (2004); and *Rush Prudential HMO v. Moran*, 536 U.S. 355 (2002). UP also was granted leave to file an *amicus* brief in *Skinner v. Northrop Grumman Retirement Plan B*, No. 10-55161 (Doc. 53) (9th Cir. 2012).

We seek to assist the Court in this case because of its potential impact on millions of employees and policyholders enrolled in employee benefit plans governed by ERISA.

SUMMARY OF THE ARGUMENT

ERISA's internal claims procedure for disability benefit claims is often a time-consuming process, necessitated by numerous factors governing the assessment of disability and the good faith exchange of information between participants and plan administrators. The time periods in ERISA's implementing regulations provide flexible deadlines, such that the internal claim and appeal process, which claimants must exhaust before they can file a lawsuit, may not be completed within a set period of time and can vary widely on a case-by-case basis. The realities of the claims course and the need for claimants and administrators to have the opportunity to resolve claims before litigation without the ticking of an accrual of any contractual limitations period is essential to maintaining the integrity of the process.

The "bright-line" rule that accrual of a limitations period starts at a final denial of a benefits claim – at the point at which the claim becomes live – will provide certainty to participants and administrators across the board. Any rule short of one that provides a clearly ascertainable statute of limitations is unworkable and will only serve to increase litigation costs and hamper participants' access to ERISA's civil enforcement scheme, in direct contradiction to one of ERISA's stated goals.

ARGUMENT

I. Accrual of a Statute of Limitations at Final Denial Protects the Internal Claims Procedure Required by Section 503 of ERISA and Its Implementing Regulations.

A. The Internal Claims Procedure for Disability Claims.

ERISA sets forth basic procedural safeguards that govern the administration of employee welfare benefit plans. 29 U.S.C. § 1133. Every employee benefit plan must: (1) provide adequate notice in writing to any participant whose claim for benefits has been denied, setting forth the specific reasons for such denial written in a manner calculated to be understood by the participant; and (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim. *Id.* With respect to the administration of disability claims, ERISA's implementing regulations provide certain minimum requirements for a participant's initial claim for benefits and for an appeal of an adverse determination. *See* 29 C.F.R. § 2560.503-1, *et seq.*

The regulations require that a plan render a decision on a benefit claim within a reasonable period of time, but not later than 45 days after the plan receives the claim. 29 C.F.R. § 2560.503-1(f)(3). However, the plan may extend the period to make a decision for up to 30 days if the administrator determines

that, due to matters beyond the plan's control, a decision cannot be rendered within that extension period. *Id.* The plan may take two 30-day extensions following the initial 45-day deadline, provided that it issues a notice which explains the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues. *Id.* The participant then has *at least* 45 days within which to provide the specified information. *Id.* The deadlines by when a plan administrator must render a determination are tolled from the date on which the plan sends notification of the extension to the claimant until the date on which the claimant responds to the request for additional information. 29 C.F.R. § 2560.503-1(f)(4). The deadlines provided by the regulations are not absolute, in certain situations providing only a floor on the time that a claimant must provide certain information. As such, a plan's initial determination on a claim may occur as quickly as 45 days following a plan's receipt of the claim or many months later.

For example, if a participant files a disability claim on January 1, the first 45-day deadline for the plan administrator to render a decision falls on February 15. The plan administrator may determine on February 10 that it requires additional information to make a decision, notifies the claimant of such, and extends the time to render a decision by the first 30-day permissible extension. The claimant must be given *at least* 45 days, to provide the plan with the

requested information before it may deny the claim. Assuming that the claimant furnishes the requested information on day 45, or March 27, the plan now has until April 26 to render a determination.

However, the plan may determine on April 25 that it again requires additional information to make a decision and notifies the claimant of the information that she must submit. The claimant must be given *at least* 45 days, or until June 9, to provide the requested information. The claimant may need additional time beyond 45 days and any plan administrator, engaging in good faith, would grant any reasonable request for an extension. Assuming that the claimant seeks and obtains an extension for a total of 60 days to furnish the requested information, or June 24, the second 30-day extension for the plan to render a decision falls on July 24. The plan issues a written denial on that date.

The regulations require that a plan give a claimant *at least* 180 days following notification of an adverse benefit determination within which to appeal such determination. 29 C.F.R. § 2560.503-1(h)(3)(i) and (h)(4). Upon the plan's receipt of the claimant's appeal, it has 45 days to render a determination. *Id.* at (i)(1)(i); (i)(3). However, if special circumstances prevent a plan from making a determination within 45 days, it may take an additional 45 days if it notifies the claimant with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. *Id.* at (i)(1)(ii);

(i)(3). If a plan extends the period of time within which it has to make a benefit determination on review due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the plan sends notification of the extension to the claimant until the date on which the claimant responds to the request for additional information. *Id.* at (i)(4).

Continuing with the above example, the claimant's appeal is due *at least* 180 days following receipt of the claim denial letter. If the claimant received the denial letter on July 24, her appeal is due by January 20, more than one year since the claimant's initial claim filing. The claimant may require additional time beyond 180 days to submit an appeal and nothing in the regulations requires that a claimant must submit an appeal within 180 days – it is a *minimum* period of time. Indeed, a plan engaging in good faith in the review process will grant a claimant any reasonable request for an extension of time. The claimant may have a medical test scheduled 60 days after the deadline which would aid the administrator in making a decision. The claimant may require an additional 60 days following the test for follow up diagnostic testing and to gather medical records. For purposes of this example, the claimant required an additional 120 days to submit all of the necessary information with her appeal, or until May 20. The plan's first 45-day deadline begins to run at that time. However, the plan determines on day 40, or June 29,

that there is still more information it needs to render a decision. It sends written notice to the claimant informing her of its need for additional information. The regulations permit tolling of the period for making a benefit determination on review until the claimant responds to the request for additional information.

If the claimant responds to the request for information within 45 days, or by August 13, the plan may take the remainder of the first 45-day period (five days in this example since the tolling period started at day 40), plus an additional 45 days, making a final determination not due until October 2. In this example, with only relatively modest extensions of time not prohibited by the regulations, an adverse claim and appeal decision took approximately 21 months from the filing of the claim. The date of the final written denial, provided that it was issued by the statutory deadline, is the absolute earliest date that the claimant may be found to have exhausted administrative remedies mandated by ERISA § 503, 29 U.S.C. § 1133, before filing suit under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B).

However, a plan may require that a participant exhaust not just one, but two levels of internal appeals, before she can file suit. *See* 29 C.F.R. § 2560.503-1(i)(3)(i); *see also Bernikow v. Xerox Corp. Long-Term Disability Income Plan*, 517 F. Supp. 2d 646, 653 (W.D.N.Y. 2007) (dismissing the plaintiff's Complaint with prejudice where the plaintiff did not exhaust the plan's second level of administrative appeal).

A mandatory second level of appeal could easily extend the claim and appeal process by an additional year for a total of nearly three years to exhaust administrative remedies.

B. Why a Full and Fair Review May – and Should – Extend the Internal Claims Procedure.

ERISA imposes "higher-than-marketplace quality" standards on plan administrators. *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 115 (2008). It underscores the particular importance of accurate claims processing by insisting that administrators provide a "full and fair review" of claim denials. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113, (1989) (quoting § 1133(2)).

As the Petitioner identifies, only a small fraction of the hundreds of thousands of disability claims filed each year end up in federal court. Brief of Petitioner at 9. The internal claims procedure described above provides the flexibility necessary for participants and administrators to work together in resolving claims short of litigation. There are a number of reasons why an internal claims procedure may extend for significant periods of time while a plan administrator is deciding a claim or reviewing an appeal of a denied claim.

First, courts generally discourage attorneys from participating in the claims process. *See Rego v. Westvaco Corp.*, 319 F.3d 140 (4th Cir. 2003). The congressional purpose of ERISA, which emphasized

promotion of "the soundness and stability of plans with respect to adequate funds to pay promised benefits," (29 U.S.C. § 1001(a)) encourages participants to resolve their claims on their own without legal counsel. Courts have recognized this purpose of ERISA in refusing to award attorneys' fees for work done during the claims and appeal process because "some claimants and some plans may use informal internal review procedures, accomplished by nonlawyers, perhaps union or other employee representatives and plan representatives; a nonliteral reading of the statute which exposed the loser to the prevailing party's attorneys' fees might undermine such a process." *Cann v. Carpenters' Pension Trust Fund for N. California*, 989 F.2d 313, 317 (9th Cir. 1993).

For lay persons, and those whose life has been transformed by disability, the intricacies of ERISA and the requirements necessary to establish a disability claim are unknown and daunting. The regulations implementing ERISA's full and fair review process recognize the necessary back and forth exchange of information by permitting the tolling of deadlines to render a decision. "In simple English, what [the regulations call] for is a meaningful dialogue between ERISA plan administrators and their beneficiaries." *Booton v. Lockheed Med. Ben. Plan*, 110 F.3d 1461, 1463 (9th Cir. 1997).

Second, in the disability claims context, there are a countless number of scenarios that justify an extended internal claims procedure with sometimes indefinite periods of tolling. For example, a diligent

administrator may be required to toll the period of time to make a benefit determination pending a response to multiple requests for medical records from a claimant's treating physician which is necessary to process the claim. *See Evans v. American Express Financial Corp. Long-Term Disability Plan*, No. 3:01-1501, 2003 WL 23126327 at *7-8 (M.D. Tenn. Nov. 5, 2003) (finding time limits for responding to claim were tolled pending the administrator's receipt of all medical information necessary to process plaintiff's claim where administrator made numerous requests to the plaintiff's treating physicians). As courts are recognizing the relevance of a finding of disability by the Social Security Administration ("SSA") (*see, e.g., Glenn*, 554 U.S. at 106; *Montour v. Hartford Life & Acc. Ins. Co.*, 588 F.3d 623, 635 (9th Cir. 2009), claimants may seek to toll a decision on their disability claim pending an award of benefits by the SSA or an administrator may request a claimant's SSA file for consideration. A process which encourages the consideration of more information, rather than less, maintains the integrity of a benefit review procedure. Indeed, this Court has recognized that a benefit determination is considered to be a fiduciary act. *Glenn*, 554 U.S. at 111. Administrators should be encouraged to take the time they need to make benefits determinations in accordance with their fiduciary duties to act for the "exclusive purpose of . . . providing benefits to participants . . . [and] in accordance with the documents and instruments governing the plan. . . ." ERISA § 404; 29 U.S.C. § 1104. Stifling the benefits determination process with a threat of the

sunset of an accrual period will lead to unnecessary litigation on a subpar claims record.

Third, claimants intending to appeal a denied claim may seek an attorney for assistance and may need additional time beyond the 180-day minimum time period to appeal. Given the importance of the administrative record to a claimant's benefit claim,[2] administrators should and typically do grant reasonable extensions of time to appeal while a claimant is seeking representation. *See, e.g., Duncan v. Hartford Life and Acc. Ins. Co.*, No. 2:11-cv-01536-GEB-CKD, 2013 WL 506465 at *2 (E.D. Cal. Feb. 8, 2013) (granting plaintiff's request for a 90-day extension for her appeal to "obtain an attorney").

As it is reasonable to expect that a disabled claimant may be overwhelmed by the amount of documentation she must obtain and submit to prove her claim, including relying on medical providers to respond to requests for information, an administrator should not be encouraged to quickly render a determination on the merits of a claim until it has all of the necessary records in order to parlay a later argument that a claimant had a reasonable amount of

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[2] Depending on the applicable judicial standard of review of a denied benefits claim under 29 U.S.C. § 1132(a)(1)(B), a reviewing court is generally limited to the claim record developed during the course of administrative exhaustion. *See Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 969-70 (9th Cir. 2006) (collecting circuit cases limiting a district court to the administrative record on abuse of discretion review).

time post-exhaustion to file a lawsuit prior to the expiration of a statute of limitations period that began accruing before it made a final decision.

II. A "Reasonableness" Standard Applied in this Context Is Unworkable and Will Create More Litigation and Uncertainty.

In lieu of a bright-line rule that accrual of a statute of limitations start no earlier than at a final benefit claim denial, which in some cases may run before a claimant can even file a lawsuit, Respondents urge this Court to adopt an extra-contractual, implied "reasonableness" requirement as that articulated by the Second Circuit in *Burke v. PriceWaterhouseCoopers LLP Long Term Disability Plan*, 572 F.3d 76 (2d Cir. 2009), which would give ERISA beneficiaries the right to challenge a plan's accrual provision on a case-by-case basis. Given the reality of benefit claim and review procedures, the requirement and expectation that participants and administrators will work together in good faith during the claim determination and review process, and ERISA's goals of soundness and stability, a case-by-case determination of reasonableness is unworkable.

A. An Accrual at Final Denial Provides Certainty.

As noted by the Petitioner, one of ERISA's central goals is to enable plan beneficiaries to learn their rights and obligations at any time by relying on the

face of written plan documents. Brief of Petitioner at 44. A claimant who has exhausted administrative remedies and is trying to ascertain her right to file a lawsuit should be able to review the plan document which sets forth a limitations period from a point in time that is easily ascertainable. An accrual period that can begin no earlier than before her claim becomes live avoids the needless speculation of what turn of events in her internal claim and review process may give her additional time to find an attorney and file a lawsuit. This need for clarity is particularly important where, as highlighted above, there are a number of different factual scenarios which may protract the internal claims review process.

There are at least two scenarios where starting the accrual period as Respondent suggests, 90 days from when a beneficiary becomes eligible for long-term disability benefits, would lead to the expiration of the statute of limitations even before there is any dispute or the plan has engaged in the claims review process. The first is where a plan accepts a late-filed claim because a state law regulating insurance requires the plan to do so unless it can show prejudice. *See UNUM Life Ins. Co. of America v. Ward*, 526 U.S. 358, 119 S. Ct. 1380 (1999). In California, this law is referred to as the "notice-prejudice" rule and it applies to ERISA-governed disability plans that are funded by insurance policies. *Id.* at 359. Although a plan may require that a disability claim be filed within 90 days of the date of disability, it cannot reject a claim filed, for example, three years after the

date of disability unless it can show prejudice. In this situation, if an accrual period started and finished before a claim was even filed, but where the claimant maintained a right to file a claim, the participant would be denied a reasonable opportunity to avail herself of ERISA's civil enforcement scheme. Instead of courts deciding on a case-by-case, state-by-state, insured plan vs. self-funded plan, basis whether equity tolls the statute of limitations, a bright-line rule that accrual starts from final denial would create uniformity in circumstances where one claimant may have the benefit of a notice-prejudice rule but where another claimant does not.

Another scenario where Respondents' proposal leads to an absurd result is where a claim was initially approved but then denied months or years later. Many denial-of-benefit claims involve claims that were approved for some period of time and then later terminated. For example, many long-term disability policies have two definitions of disability: disability from one's own job and disability from any job that the claimant may perform. Plans conducting reviews at the juncture of a change in the definition of disability will often terminate a claim for benefits. Before a claimant can exhaust the appeals process for the termination of her benefits, she will be outside of the contractually shortened statute of limitations. Although a court could toll the statute pending the claimant's exhaustion of internal remedies, it is unnecessarily laborious to engage in any analysis of tolling and equity in these situations which occur so

frequently and where a bright-line rule would apply the same result to a claimant whose claim was denied off the bat and to a claimant whose claim was paid for several years before a termination of benefits.

B. A "Reasonableness" Standard Will Create Unnecessary Litigation and Increase Costs of Suit.

As this Court has recognized: "Benefits decisions arise in too many contexts, concern too many circumstances . . . for special procedural rules [which] would create further complexity, adding time and expense to a process that may already be too costly for many of those who seek redress." *Glenn*, 554 U.S. at 116-17. Allowing the internal claims procedure the time to take its course without the pressure of a ticking time of accrual will limit the burden on the federal courts to decide claims that may have otherwise been approved in the absence of a lawsuit. A number of claims are resolved in favor of a participant even after the period of time set forth by the regulations. *See* 29 C.F.R. § 2560.503-1(f)(1); *Dunnigan v. Metropolitan Life Ins Co.*, 214 F.R.D. 125 (S.D.N.Y. 2003) (involving putative class of participants whose claim for long-term disability benefits were approved beyond the 90 days after they were submitted without any notice of the need for an extension of time as required by ERISA).

Because "reasonableness" determined on a case-by-case basis creates uncertainty, it may be litigated

as a threshold issue in many denial of benefit claims, requiring reviewing courts to parse which circumstances in a claim process tolled the statute of limitations. This nit-picking of the claims process is hardly desirable with the alternative of a clear bright-line rule. A judicial inquiry into the claims process to determine "reasonableness" could also lead to costly discovery disputes as plaintiffs attempt to uncover procedural irregularities and conflicts of interest which contributed to unnecessary tolling or unreasonable requests for information by administrators. Although a reviewing court is generally limited to the administrative paper record in reviewing whether an administrator abused its discretion, *see Abatie*, 458 F.3d at 969-70, determining whether there are factors that contribute to the reasonableness of a limitations accrual may require an inquiry into matters beyond the administrative record. A bright-line rule would eliminate the need for costly litigation that does not contribute to a judicial assessment as to whether or not a participant is disabled.

C. Uncertainty Regarding the Accrual of the Statute of Limitations Will Hamper Participants' Access to ERISA's Remedial Regime.

One of ERISA's goals is to provide participants with ready access to the courts. 29 U.S.C. § 1001(b). Participants already have a difficult time finding

knowledgeable attorneys to handle ERISA benefit claims,[3] such that a rule that creates uncertainty about whether or not a lawsuit may be timely filed would create even more barriers for participants trying to exercise their rights under ERISA.

First, a participant who has just been denied income replacement benefits because she is not gainfully employable due to a medical condition is often in a multi-factor crisis situation. Instead of relying on benefits that she believed would protect her and her family against the hardship of disability, she is now in the midst of making alternative arrangements to fund basic life necessities and medical treatment. While battling a medical condition that has deprived her of the ability to care for herself, she now has to fight a denial of a benefit claim against a large company. It may take her several weeks, months, or years to get her life in order before having the wherewithal to seek out the small community of ERISA attorneys who may be willing to take her case. *See, e.g.*, *Steffy v. Liberty Life Assur. Co. of Boston*,

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[3] The ERISA bar representing individuals is extremely small. For example, in 2010, there were 852 attorney members of the Employee Benefit Committee of the Section of Labor and Employment Law of the American Bar Association; of those, only 101 classified themselves as representing Employee-Plaintiffs, or approximately less than twelve percent (12%) of the total membership. Brief of AARP and National Employment Lawyers Association, as *Amici Curiae*, in Support of Petitioner, *Hardt v. Reliance Standard Life Ins. Co.*, 2010 WL 768489 (U.S.) (Appellate Brief).

No. 09-538, 2009 WL 3255219 (W.D. Penn. Oct. 7, 2009) (due, in part, to cognitive difficulties stemming from dementia, participant missed deadline to file a claim). Although written denial letters inform claimants of their right to file suit, they typically do not inform, nor do courts require that they inform, claimants of the deadline by when they must do so. *See Scharff v. Raytheon Co. Short Term Disability Plan*, 581 F.3d 899, 907-08 (9th Cir. 2009) (rejecting plaintiff's claim that administrator was obligated under ERISA to inform her of the deadline to file suit).

Absent a clear bright-line rule governing the accrual of a statute of limitations, *i.e.*, x number of years from the date of a final denial letter informing a claimant that she has exhausted administrative remedies and may now bring an action under § 502(a) (29 C.F.R. § 2560.503-1(j)(4)), determining whether or not a statute of limitations has run or might be tolled may be a time-consuming process. An attorney evaluating whether she is willing to represent a claimant who has exhausted administrative remedies on her own will have the additional challenge of determining whether or not a lawsuit may be timely filed, and while making that determination, be compelled to file a lawsuit to protect against any further accrual of the statute of limitations or risk a malpractice claim if the statute of limitations is later found to have run while the attorney was in the process of evaluating a claim for litigation.

As part of competently evaluating a claim for litigation, an attorney will need to do some investigation,

which includes requesting a copy of the participant's claim file and a copy of all plan documents. ERISA's regulations require that an administrator rendering an adverse benefit determination on review provide written notice informing a claimant that she is entitled to receive, upon request and free of charge, copies of all documents, records, and other information relevant to her claim for benefits. 29 C.F.R. § 2560.503-1(j)(3); (m)(8). Plan administrators must also provide claimants with plan documents within 30 days of a written request. 29 U.S.C. § 1024(b); 29 U.S.C. § 1132(c). Operating under the bright-line rule proposed by Petitioner, an attorney would simply need to review a final denial letter and the Plan document, which may or may not set forth a contractually shortened limitations period, in order to ascertain quickly the deadline for filing suit.

Under the "reasonableness" standard, the determination of the statute of limitations is muddy. Take the above example of an internal claims review process and the contractual statute of limitations in the present case: three years after the time written proof of loss is required to be furnished according to the terms of the policy. Br. in Opp'n (BIO) App. 5a, 7a. Written proof of loss is due 90 days from when a beneficiary becomes eligible for long-term disability benefits. *Id.* at 5a. In the example, where tolling and two levels of appeal took three years, at the time of final denial, the three-year period has run. Even if a participant found an ERISA attorney the next day, who immediately requested the claim file and plan

documents, received the documents within 30 days, and reviewed everything with heroic speed, the attorney must decide in haste whether to take the case and file a complaint. If the attorney decides that she is unable to take the case and makes a referral, the participant must now find and consult with other attorneys who now have almost no time to file suit unless they determine that the statute of limitations will be tolled for the exhausted claimant. As most participants exhaust administrative remedies without attorney representation, the reality of a "reasonableness" approach will create unacceptable consequences for claimants who must be protected by a procedure that gives them ready access to the courts in the event of a wrongful benefit denial. After all, the E in ERISA stands for Employee.

CONCLUSION

For the foregoing reasons, United Policyholders urges the Court to reverse the decision of the Second Circuit Court of Appeals.

Respectfully submitted,

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